DOCUMENT RESUME

ED 041 420 EC 006 003

AUTHOR	Cohen, Julius S., Ed.
TITLE	Manpower and Mental Retardation: An Exploration of the Issues. Proceedings of the Banff International Conference (Banff, Alberta, Canada, June 23-25, 1969).
INSTITUTION	President's Committee on Mental Retardation, Washington, D.C.
PUB DATE	69
NOTE	92p.
EDRS PRICE	EDRS Price MF-$0.50 HC-$4.70
DESCRIPTORS	Conference Reports, *Exceptional Child Education, International Programs, *Manpower Needs, Manpower Utilization, *Mentally Handicapped, *Personnel, Personnel Needs, *Professional Education

ABSTRACT

Presented are the proceedings of the 1969 Banff International Conference on Manpower in Mental Retardation. The opening and keynote addresses discuss utilization of personnel, estimating manpower shortages, sources of more personnel, and means of obtaining more effective recruiting and more productive field personnel. An introductory statement and discussion highlights are recorded for each of the following areas: problems in training program development, training basic and supportive personnel, and international and interuniversity relationships. A summary discussion and list of conference invitees are included. (KW)

ED041420

Manpower and Mental Retardation an Exploration of the Issues

PROCEEDINGS OF A JOINT
UNITED STATES-CANADA CONFERENCE: 1970

The President's Committee on Mental Retardation publishes this proceedings report on behalf of the participants in the Canadian-United States Joint Study Group on Mental Retardation. The report, on which the Committee has taken no position, is presented for the information of professional and voluntary organization workers in the field of mental retardation. The Committee's views on manpower utilization in mental retardation programs appear in its 1967, 1968 and 1969 reports to the President of the United States.

CANADIAN-UNITED STATES JOINT STUDY GROUP ON MENTAL RETARDATION (1969 members)

W. A. Cochrane, M.D., The University of Calgary, Calgary, Alberta

Julius S. Cohen, Ed.D., The University of Michigan, Ann Arbor, Michigan

William M. Cruickshank, Ph.D., The University of Michigan, Ann Arbor, Michigan

Patrick J. Doyle, M.D., Georgetown University, Washington, D.C.

Robert Kugel, M.D., The University of Nebraska, Omaha, Nebraska

M. S. Rabinovitch, Ph.D., McGill University, Montreal, Quebec

David B. Ray, Jr., President's Committee on Mental Retardation, Washington, D.C.

G. Allan Roeher, Ph.D., National Institute on Mental Retardation, Toronto, Ontario

ED0 41420

MANPOWER AND MENTAL RETARDATION:
AN EXPLORATION OF THE ISSUES

The Proceedings of the Banff International Conference
Banff, Alberta, Canada
June 23-25, 1969

Edited by

Julius S. Cohen, Ed.D.
Institute for the Study of Mental Retardation
The University of Michigan

Conference Sponsored by:
National Institute of Child Health and Human Development
President's Committee on Mental Retardation
Canadian Association for the Mentally Retarded

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
OFFICE OF EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL OFFICE OF EDUCATION POSITION OR POLICY.

PREFACE

Patrick J. Doyle and David B. Ray, Jr.

The President's Committee on Mental Retardation is pleased to bring the Proceedings of the Banff International Conference on Manpower in Mental Retardation to your attention.

The first Inter-American Conference on Mental Retardation was held in Puerto Rico in 1965. This meeting brought together leading educators, physicians, administrators and rehabilitation workers from South America, the United States, and Canada. A number of recommendations were made at this conference, among which was one suggesting that small international meetings be hosted by various participating countries.

As a result, there have been meetings in Montevideo, Bogota and Mexico City under the guidance of the Children's Inter-American Institute of Uruguay. In each of these, the President's Committee and appropriate federal agencies participated in the conference planning.

The Banff meeting is also an outcome of the first Inter-American conference.

It is the hope of PCMR that the Banff International Conference on Manpower in Mental Retardation is only the first step toward a collaborative working relationship between the two countries. The President's Committee is exceedingly pleased to have been a part of this joint effort and is most grateful to the National Institute of Child Health and Human Development for the contract grant that helped to finance the conference.

F O R E W O R D

William Cochrane, M.D.

In 1965 the First Inter-American Conference on Mental Retardation was called by the Department of Health, Education and Welfare, to be held in Puerto Rico. Earlier, this meeting had been planned by the Office of the Special Assistant for Mental Retardation to President Kennedy.

Out of the Puerto Rico meeting came a recommendation for more international educational programs in mental retardation. Consequently, early in 1968, Dr. Patrick Doyle, a member of the President's Committee on Mental Retardation, and Dr. William Cochrane suggested a follow-up meeting might be held in Banff, Alberta, Canada. An international association of four universities--the University of Calgary, McGill University, the University of Nebraska and the University of Michigan--was proposed. A Joint Study Group was developed consisting of Dr. Julius Cohen and Dr. William Cruickshank of the University of Michigan, Dr. Doyle and Mr. Ray of PCMR, Dr. M. S. Rabinovitch of McGill University, and Dr. Robert Kugel, the University of Nebraska, with Dr. Cochrane being named chairman of the group. Dr. Allan Roeher, National Director of the Canadian Association for the Mentally Retarded, joined the joint study group at a meeting held on June 2, 1968.

It was proposed that an international seminar be held, with its focus on the problem of mental retardation manpower training on an international inter-university level, with emphasis on an exploration of new relationships and patterns. It was further decided that the general theme would be related to manpower requirements in the 1970's, especially the need for cooperative development of educational resources in meeting these requirements. There was agreement that an interdisciplinary approach would be the most effective way of exploring the manpower problem. The joint study group suggested that the seminar be entitled "International Seminar: Manpower Needs in Mental Retardation." The program committee, composed of Dr. Cochrane and Dr. Cohen, reflected this point of view.

The Planning Committee enumerated certain explicit purposes of the meeting, which were to:

(1) provide an opportunity for contacts and liaison with key people in the various educational and health professions in Canada and the United States with a particular interest in the problem of mental retardation;

(2) bring about an exchange of ideas and information regarding training in mental retardation; and

(3) serve as a model for eventual program development with underdeveloped countries, but focusing initially on problems in the United States and Canada.

It was decided that the purposes of the seminar would be served best by limiting the number of participants. Invitations to the closed workshop were extended so as to ensure both a disciplinary and a geographic balance. It was also intended that those who had made significant contributions and had demonstrated a definite interest in mental retardation, particularly in the training of personnel, be included.

Dr. Leonard Mayo, Professor of Human Development at Colby College, Waterville Maine, and Robert Shaw, Vice-Principal (Business), McGill University, were invited to be keynote speakers and to open the discussions. Their presentations on the first day were to be followed by a general discussion. Later, small group discussions were scheduled, following three basic themes: (1) Problems in Training Program Development, (2) Training Basic and Supportive Personnel, and (3) International and Inter-University Relationships.

Financial assistance was provided by grants from the National Institute of Child Health and Human Development through the President's Committee on Mental Retardation, and the Canadian Association for Retarded Children.

The meeting was held at the Banff School of Fine Arts, Banff, Alberta, Canada, on June 22-25, 1969.

TABLE OF CONTENTS

Preface - Patrick J. Doyle and David B. Ray, Jr. iii

Foreword - William Cochrane v

Introduction - Julius S. Cohen 1

General Session

Opening Address - Robert F. Shaw 7
Keynote Address - L. W. Mayo 17
Discussion Highlights 29

Theme I: Problems in Training Program Development

Introductory Statement - Darrel J. Mase 35
Discussion Highlights 45

Theme II: Training Basic and Supportive Personnel

Introductory Statement - Cyril Greenland 51
Discussion Highlights 70

Theme III: International and Inter-University Relationships

Introductory Statement - Patrick J. Doyle 77
Discussion Highlights 82

Summary Session

Discussion Highlights 87
Summary - L. W. Mayo 91

List of Invitees 93

INTRODUCTION

Julius S. Cohen

In the past two decades, there has been a great growth in the awareness of and concern for the problems of the mentally retarded, with this area serving as a focus for the work of scientists concerned with human growth and development and learning. The advance in scientific knowledge has encouraged a large expansion in the programs for the retarded, and there has been an increasing emphasis on aspects related to prevention, early detection, and treatment.

One of the largest problems facing the field during the decade of the Seventies is that of manpower: educating newcomers for service in the field; providing in-service training experiences for those already actively involved in programs for the retarded; and educating personnel in related areas and the general public to the needs and abilities of the retarded. Thus, the field is faced not only with problems of securing sufficient numbers of personnel, but also with problems of bringing the available knowledge into play in the most effective way to the most people. It was with these thoughts in mind that a small group of university faculty from Canada and the United States and representatives of the President's Committee on Mental Retardation met to discuss manpower problems.

As the variety and complexity of the problems were considered, it became evident that a Canadian-United States consortium which would permit individuals from these two countries to explore their common problems, exchange ideas and practices, and develop a more formal basis for extended cooperation in the manpower field would be very desirable.

The Banff Conference, however, went beyond its initial goals of exploring manpower problems and developing a basis for further directions and a guideline for international cooperation. There was also a broad exploration of the issues related to service delivery systems and agreement on the desirability of identifying areas for further development. The general conclusions reached during the conference suggested several factors that should be considered in the future.

First, it seems desirable to develop strong ties between the northern states and Canada. For instance, universities could pair off on a regional basis: perhaps British Columbia and the University of Victoria with the Universities of Washington and Oregon in the Far West; Saskatchewan and Calgary with Minnesota in mid-continent; York, Toronto, and Western Ontario with Michigan universities in the Midwest; McGill and Montreal with New York state and Dalhousie with New England universities in the East. Governmental agencies and public and private services programs can cooperate in the same way on a regional basis, providing staff a broader exposure to the problems in the field and the techniques which are being used to solve them. In addition, it was felt that there should be a strong relationship of manpower programs in retardation with the activities and efforts of labor and industry.

The conference group felt that one of the strengths of a Canadian-United States consortium would be the development of a repository of people involved in service and training and also laymen, all of whom might assist in meeting the needs of this field and establishing a basis for an international exchange to enhance programs for the retarded. The exchange was seen to operate on three levels: an exchange of information, an exchange of personnel, and an exchange of students.

Information generated by programs and through research frequently does not find its way into the service programs. This problem is complicated when national boundaries must be crossed, and potential contributions are overlooked because of cultural or language barriers. In general, these two barriers are not a major problem between Canada and the United States, and a desirable exchange of information certainly is feasible.

Exchange of personnel was seen as an excellent technique to expose staff to new developments in other programs in a meaningful way and as an opportunity to encourage and reward the growth and activities of non-professional staff members. Such a program would provide many opportunities for in-service staff development and, at the same time, provide cooperating programs with a nucleus of staff who could bring back new techniques and approaches to service in the field.

Student exchange presents a unique situation. It is obvious that university programs are not equally strong in all areas and frequently each has a unique contribution to make in the training of students. Rather than having each university attempt to do all things in the field, it was felt that an exchange of students could bring about more efficient use of the training manpower available. Practicum experiences or some specialized courses could be shared by universities. Faculty exchange would also be beneficial. It was suggested, therefore, that the universities on both sides of the border might pair up and identify specific areas in which such student and faculty exchanges would be of value.

Moreover, through the joint study group, it was believed that a "pool" of people could be established, to be drawn upon by programs in both countries to enrich their efforts. This pool would be made up of individuals primarily involved with training, service, research, or community agencies representing the retarded, the employers or other citizen's groups who could assist in providing for the needs of the retarded.

In view of the reactions of the participants and the apparent value of the conference, the joint study group decided that widespread dissemination of the results of the Banff Conference would be desirable. Moreover, since a significant portion of Canada could use the material best if it were available in French, it was decided to provide full English and French versions of the materials. The President's Committee on Mental Retardation and the Canadian Association for the Mentally Retarded have assumed the responsibility to ensure that both English and French versions are published.

The format of the proceedings follows that of the meeting itself: a formal statement is presented, followed by a group discussion. In this report, the editor has attempted to bring the reader the essence of the discussions in the form of a brief summary of their highlights.

After the opening general session, with addresses by R. F. Shaw and L. W. Mayo, the conference turned to three sub-themes, each session dealing with a separate aspect of the general problem of manpower training. The themes, and the introductory speakers, were:

I. Problems in Training Program Development--Darrel J. Mase
II. Training Basic and Supportive Personnel--Cyril Greenland
III. Inter-University and International Relationships--Patrick J. Doyle

A summary session followed, with a discussion of the over-all conference. This discussion is presented under a final discussion highlights section. Dr. L. W. Mayo closed the conference with a summary.

The proceedings are concluded with a list of conference participants.

The editor wishes to extend his sincere appreciation to Jeannine Guindon and Denis Lazure, participants at the conference, for assuming full responsibility for the French language translation of these materials.

The materials were edited from prepared papers, tapes, and notes made by conference recorders. The editor wishes to thank Don Fields, Nancy Marlett, Dr. John Read and Velma Trowbridge, the conference recorders, and Trudy Carlyle who coordinated their activities. Moreover, sincere appreciation is extended to Ralph Berets and Catherine Rader, who assisted in the editorial process.

Encouraged by the reactions at the conference, the joint study group is continuing its activities. This exploration of issues in manpower is seen as the first of a series of conferences between personnel from Canada and the United States which, ultimately, should improve the lives of the mentally retarded in both countries.

GENERAL SESSION

MANPOWER NEEDS IN MENTAL RETARDATION

Robert F. Shaw*

From the list of participants and their titles, I am well aware of the select and eminent specialists which this groups represents. I certainly appreciate my precarious position in attempting to comment on a subject as complex as personnel needs in the field of mental retardation. The materials which have been circulated provide a clear indication of the monumental task which this International Seminar on Manpower Needs in Mental Retardation is about to undertake.

The combined wealth of experience and knowledge of this group is such that, as a layman in your field, I cannot be expected to suggest any solutions. If I can be of any value, it must be in a form of raising some questions, questions which come to the mind of one who had been associated as a volunteer in a general organization and policy capacity within the mental retardation movement. My question asking is rendered dangerous by the fact that I am a university administrator and, therefore, an "activist." I believe that hallowed ground should be trodden by the untrained public. I believe that a wider base of participation in decision-making and action improves the result.

As a citizen deeply interested in the alleviation, or, ideally, the elimination of the problem of retardation, I agree wholeheartedly with the echoing and reechoing of pleas for more money, more training facilities, more recruitment, more research and more public action directed to improving the number and quality of professional people in this field. I am also optimistic enough to believe that there will be steady improvement in these areas in the future.

As a university administrator, and as past president of Canada's national voluntary organization serving the retarded, I cannot help but be impressed with the arguments raised which deal not only with the mental retardation manpower problem as such, but which contract the situation with professional manpower shortage in general. There is voluminous literature, making a convincing case for the need for more and better trained people in the field of mental retardation. I hope that this symposium will do more than merely echo the arguments already made. I trust that you will evolve guidelines for the future of those public and private agencies which must provide the financial and other resources for solving manpower problems. The agencies to which we look for the means to improve the situation in the mental retardation field are under equal pressure to do likewise to meet the manpower requirements for a wide range of other general and specialized problem areas. There is a lineup of many groups knocking on the same doors, presenting the manpower needs of their own areas.

---

*Vice-Principal (Administration) McGill University; Past President, Canadian Association for the Mentally Retarded; formerly Deputy Commissioner General and Commissioner General, Expo '67, and President, The Foundation Company of Canada, Ltd.

6/7

In these circumstances, government and private agencies cannot solve everyone's problems by meeting and satisfying everyone's demands. They can, at best, evolve some form of compromise, or system of priorities. Inevitably this means only partial support for each problem area. Regrettably, the problem is complicated by the fact that the attrition of persons from specialized fields tends to reduce the net gain provided by new recruits and graduates.

Public officials are doing their own analyses which do not always agree with those of the special interest groups. In fact, the special interest groups are being told bluntly that it is time they learned to resolve problems of manpower shortages by other than the traditional ways of requesting more money and more training programs.

The Canadian Minister of National Health and Welfare has emphasized this point recently with respect to medical and hospital personnel. He stated that Canada would have enough doctors to serve its health needs if only the distribution and practice patterns were better planned and set up more fairly. He said the same applies to the hospital facilities in Canada. He indicated that, given the right distribution and treatment patterns, existing hospitals would be able to give more service without any negative effect on the quality of care rendered. The minister, in his urging of a more efficient plan, added, "Let me state plainly that it is my feeling that if the hospitals and other health facilities in this country will not get together to coordinate their services and divide their specialized functions, then my provincial colleagues and I will have to give serious thought to the selective use of government funds to foster this goal ourselves."

Blunt talk from the head of a department which has been a major national supporter of training funds for the social and health professions. Is it fair criticism? Does it apply to other professional areas? Does it pertain to the areas of special education and rehabilitation? How well are we utilizing the special personnel and facility resources now available in mental retardation? How much manpower are we wasting through our current approach to problem-solving?

Recently, one of the lay workers of the Canadian Association for the Mentally Retarded visited a family seeking help for its retarded child. The visit revealed that some half-dozen agencies, each operating in isolation from the others, had been working with this family for some time. Moreover, regular visits were being made by professional staff from each of these agencies at monthly intervals. Is this an isolated or rare example? I think not! What a waste of human and economic resources! The lay worker, shocked at this designing, took it upon herself to meet with all of the involved agencies to work out a co-ordinated plan. This quickly resulted in ameliorating the problems of duplication and, at the same time, doing something constructive for the family.

The Canadian Association for the Mentally Retarded is doing something to fight the waste of duplication generally. It has joined forces with five other national organizations in Canada to sponsor a 3-year study of special problems relating to children. A Commission on Emotional and Learning Disorders in Children was established for this purpose.

Expert task groups have studied community agencies in various parts of the country with respect to their functions as well as the effectiveness of their services. The report of the commission is not yet published. However, I do know that the task forces were shocked at the low efficiency of the existing agency resources. This seemed to result from failure to deliver services effectively rather than from shortage of personnel. It seemed to be linked to poor organization of agency services and to less than optimal use of professional time and talent.

While we might argue that clinical and professional people should not be subjected to the same kind of efficiency standards as are demanded in the field of business production, we can hardly rationalize inefficient utilization of expensively acquired training and experience, especially in the face of staff shortages and critical unmet needs.

A few professional people are courageous enough to suggest that entrenched, protectionist practices within disciplines lie beneath this problem and that such practices are obsolete in these modern times. We must work to remove the psychological fears and insecurities that cause the protection surrounding professionalism.

One eminent medical leader frankly admits he left clinical practice because he felt he could make a greater contribution in organization and administration of medical services and because he believed that his talent and experience were underutilized. He felt that three-quarters of the work he was doing could have been performed by well-trained technicians.

There has been real progress along these lines in my own profession of engineering. Not long ago I had the pleasure of addressing the graduating class at St. Lawrence College in Ontario. This school trains specialists up to the level of technologist. During the dinner which preceded the ceremony, the director of the engineering school told me that the course followed for the diploma of Engineer Technologist was the same as that which won him a bachelor's degree in engineering 6 years ago. My reply was that I had a bachelor's degree 36 years ago. Progress is hard on the ego!

The Canadian Association for the Mentally Retarded convened a meeting of special educators in which serious questions were raised about the effectiveness of current special education. Questions were raised concerning the validity of the so-called special training and the effects of the quasi-isolated milieu in which teachers so frequently function. If I recall correctly, it was the opinion of the meeting that the correlation between increased special training and effectiveness as a teacher was insignificant.

I believe that serious questions can be raised about the imbalance in distribution of professional staff time among diagnosis, treatment, counseling, and training. Our parents complain that their children are being "diagnosed to death," often for research purposes, but that there is a dismal lack of interest in follow-through in the form of implementation of programs.

What kinds of professional people are we creating with our training methods? What is the justification for pushing the doctorate as the minimum qualification, only to find that we are creating a population of not-quite clinicians and not-quite researchers? If all our money and efforts are focused on training specialists, then who is concerned with doing something about the legion of workers needed to perform the more routine, but essential tasks of training and care.

By focusing only on the specialist, universities and professional organizations seem to be encouraging the development of a relatively small group of highly trained specialists at one end of the spectrum and an army of untrained personnel at the other end--with a semi-vacuum existing in the middle. Attempting to fill this vast middle void with specialists may be the ideal, but it is unrealistic. What are professional groups doing to evolve an answer to this problem? If they do not act promptly, I fear that the search for solutions will be attempted by private and public bodies in isolation from the universities and professional associations.

Historically, universities and professional associations react to challenges by closing ranks, becoming more insular. These defense mechanisms may preserve the professional group but they don't resolve problems.

Some complain that after having pioneered new fields and encouraged professional people to become involved in such new developments as mental retardation, lay groups frequently are rejected as no longer useful. However, today there are some signs of established institutions reversing this trend. Modern hospitals combat the problems of limited professional help by the use of paramedical professional and nonprofessional help, and by the use of trained volunteers. So far, I see little evidence of this kind of mobilization in the fields of education, psychology, or social work. We do see examples, however, of outright rejection of improved training methods which involve "outsiders."

Almost 4 years ago the Canadian Association for the Mentally Retarded wished to introduce the school-work or work-study experience program into one of the Canadian provinces to provide a better preparation for individuals with emotional, behavioral and learning problems for their place in our work-oriented culture. Many of you are, of course, familiar with the value and success of this type of program in the United States. Also it has been adopted successfully in the preparation of normal work forces in underdeveloped countries. In the Canadian project, it was necessary, ultimately, to do a bit of rare reverse financing. Voluntary funds actually were paid into a public education agency to persuade it to employ an individual to launch a pilot program. Considering the success of this type of program in other countries, it is no surprise that the project proved successful in our own experimental area.

Subsequently, in order to promote and interpret this successful experience in other provinces, the association financed a cross-country tour for the project's chief staff officer. His experience was interesting. The greatest resistance and objections did not come from employers, or the parents of the handicapped, or the public. It came from the educators. The program did not fit the established pattern. It exposed the education system to the active partnership of "insignificant others," who were not part of the establishment.

Will our blind worship of the university graduation certificate, of minimum academic standards and "nothing in between" really solve our problem?

We live in a world that is moving and changing too fast, a world that is too complex for the survival of the insular approach to education We must be in constant touch with the student, the user, and the public if we are to create and maintain true centers of learning. This is the cry of young people throughout the world -- the vast majority of the activist generation. Don't get me wrong. I don't mean revoluntionaries, I mean all thoughtful young people.

I recognize that it is dangerous to generalize. It is equally unwise to raise a defensive curtain around the issues or to blindly defend the status quo.

As the Minister of National Health and Welfare has warned, if the professionals resist public pressure, then government will bring influence to bear through the selective use of government funds.

Such forced intervention can leave a bad situation. Think, for example, of the effect the development of a new profession in rehabilitation counseling had on the field of social work. By its inaction, this discipline missed a golden opportunity to become the coordinating and counseling discipline in the field of social and vocational rehabilitation.

But public and private agencies must move on their own if the professions and universities fail to give leadership. We are already beginning to see such unilateral actions and resulting problems. Training for careers in nursing, social work, and mental retardation at the community college level already suffers from a lack of essential integration and recognition in counterpart professional groups.

I believe a heterogeneous interdisciplinary group of dedicated and committed specialists like you must push the thinking process toward better solutions than have been advanced to date. Industry, when faced with a manpower shortage (or excessive cost of labor) approaches problems of this kind in a twofold manner:

- -- First, it analyzes the tasks involved in the jobs where a shortage of manpower has developed. From this it determines which tasks can be automated or transferred to other less skilled workers (provided the union permits it);
- -- Second, it works with (or without) government to plan new training and retraining resources to take up the slack.

Vital elements are involved in this process:

- -- Self analysis;
- -- Transfer of function where possible;
- -- Regional and national planning;
- -- Public-private partnership approach;
- -- Coordinated training activities.

Applying these guidelines to your situation, I submit that you should begin with self analysis to determine how the time of professional people can be utilized to obtain maximum possible use and benefit from their skills. I suspect that this would result in a plan to recognize and utilize subprofessional help and to integrate such efforts with preparation for professional work.

I believe that you will then decide to utilize people and agencies who can help you. In organizing this international seminar, you have, in fact, involved public and private agencies. But I don't notice any professional job analysts or efficiency experts present. Maybe you too need diagnosis, some objective research in analyzing your professional needs and conduct. When you are called into my house as an outside expert you insist on a strict methodology to analyze my problems. Maybe you should also be prepared to bring in "outsiders" to help you. The "cross-disciplinary in-family" membership at meetings of this kind is a step in this direction. It is effective because of the candid dialogue which it produces. But will it really reach to the core of the problem? Can we be our own analysts? Our own problem-solvers? Are we really manpower specialists? Maybe, but the University of Toronto called in outside consultants to advise on the reorganization of its health sciences faculties.

I have raised the kinds of questions which bother the parents, workers, and administrators and the public, who are on the outside looking in. These are the people who raise and vote huge sums of money for research, training, and the building of special facilities. They hear of endless surveys and research projects which are under way. Their children are the subjects of such surveys and research, diagnosis and rediagnosis, and of shunting between professionals and agencies. Quite frankly, there is some disenchantment. Many of these parents are university graduates themselves and have the abilities and talents to organize complex programs. They will not continue to sit back and wait for you. The aggressive leadership manifested by the parents of the retarded, and more recently by those of children with "learning disabilities," is evidence of a new breed of volunteers and voluntary organizations willing and able (hopefully with the help of professional and seasoned program planners) to break with tradition and launch highly complex and sophisticated developments. Governments, faced with spiraling costs of education and ever-increasing demands for more health, education and social services, are prepared to support those who offer realistic strategies and who can plan and develop on a coordinated region-wide or nationwide scale.

We have a good example of the value of essential partnership approaches to effective tackling of seemingly impossible goals in the Centennial Nationwide Series of Demonstration and Research Projects of Mental Retardation, recently developed by the Canadian Association for the Mentally Retarded. It is a 7-year development with 2 years of planning, negotiations and fund raising, and 5 years for developing the projects.

Briefly, this plan has resulted in the establishment of:

- -- Seven projects in the form of university-affiliated centers for mental retardation;
- -- Three programs as model community development projects;
- -- One project as a provincewide development in schoolwork services;
- -- One activity as a National Institute on Mental Retardation.

This centennial plan, concerned with stimulating research, personnel preparation and improved direct services to the retarded throughout the country, was launched with a borrowed $100,000 and has developed into a $15,000,000 project. Alberta has three projects under way. The support came from industry, the federal government (a special 2-1/2 million dollar grant), special grants from provincial governments, service clubs (e.g., $350,000 from the Kinsmen), and from the use of existing statutory funds.

The program is far from perfect, but it does demonstrate that resources do exist which can be tapped on a nationwide scale and that a volunteer organization can plan and execute such a project in concert with universities, government at all levels, and the private sector.

Canada now has, at least, a skeleton framework and machinery from which to build an integrated approach to problem solving on behalf of the mentally retarded. The National Institute on Mental Retardation has a vital role to pay in this respect.

Within this global plan must be maximum opportunities to experiment on an individual basis. Nevertheless, the time already has come when we must assimilate the varied experience and knowledge gained and move beyond the world of endless fragmentation toward combined operations. The time has come to go to federal and provincial governments, universities, community colleges and other training institutions with a long-range comprehensive plan which takes into account not only research needs and the needs of highly trained specialists, but also a sensible, feasible, practical approach to improved direct care for the handicapped.

I suspect that the specific items of needed knowledge or information to resolve the manpower problem are known (even if in fragmented fashion). Each of you has pioneered in this field and each has a contribution to make. Let us not lose the golden opportunity which this gathering offers to point the way to a solid resolution of the problem.

Let me challenge you with the proposition that right now there are enough resources in this country, and in the United States, to resolve the manpower problem within the next 5 years. Moreover, that governments and universities are prepared to support a plan which will materialize or tap these potential and actual resources and to provide an improved level of utilization.

I might add that I am well aware of the fact that most people will say it can't be done. Just that was said of the CAMR Centennial Plan; and it was said of Expo '67. Such things will always be said by people who lack the vision, knowledge, and courage to adjust to our rapidly changing world. Give the programs and funders a sound and realistic plan, and they will implement it. This is your responsibility over the next several days while here in Banff, and, more importantly, over the rest of your careers. How would you advise that we go about these tasks?

MANPOWER FOR MENTAL RETARDATION

Leonard W. Mayo
Professor of Human Development
Colby College
Waterville, Maine

After having read innumerable reports, done considerable research and talked with a good number of informed people, I still feel inadequate about performing the task assigned me. In fact, I sympathize with the college student who concluded a lengthy and perceptive paper on "What's wrong with America" with the following words: "To my dismay, I have found myself unable to outline an actual set of plans for the restructuring of our society. This is due not so much to the difficulty of the subject as to a sense of personal inadequacy." I must confess to the same feeling of inadequacy and at the outset throw myself on the mercy of the court.

It is impossible to discuss manpower problems in mental retardation without touching, in one way or another, on the entire spectrum of the field. Hence this paper will take a fairly broad approach to the problem.

It has been wisely said that the first step toward solving any problem is to ask the right questions. I suggest the following questions as fundamental for seeking solutions to manpower problems in mental retardation:

1. What is a true manpower shortage?
2. Have we mastered the techniques of selection, collation, and interpretation of data that will insure adequate estimates of current and future needs?
3. What are the main categories of personnel that must be augmented if mental retardation services are to be properly manned; and what sources must be tapped to find them?
4. Finally, what can be done to make the challenge of mental retardation more compelling; recruiting more effective; relations with essential professions closer; and personnel now in the field more productive and secure?

Practical answers to these questions will emerge through close cooperation between countries, universities and agencies. Hence this international conference can be seen as an important step toward meeting this goal, which I heartily welcome.

1. What is a True Manpower Shortage?

As far as I know, we have yet to establish an accepted definition of a manpower shortage, but it is relatively easy to identify pseudo-shortages. For example, if a superintendent of schools heard from several of his principals that they were unable to find a sufficient number of janitors to meet their needs, he would doubtless conclude, if he were wise, that the report was not literally true. For what the principals meant, quite literally, was that they were unable to find enough applicants willing to perform certain duties, in a given setting, for a specified number of hours each day, at a given wage. That was known; what was not known was whether a substantial change in one of these factors, or a modest change in several, would have made a difference in the number of applicants for the jobs available. Since in current retardation services duties are demanding, facilities poor, the hours long, the salary low, promotions few and far between, and retirement provisions inadequate, a dearth of applications from qualified people is to be expected. Under such conditions there is a shortage, and indeed there should be.

The lack of qualified professional staff in mental retardation is due in part to the same set of factors, plus two additional causes: first, because most of the professions essential to the evaluation, education and training of the mentally retarded have not given adequate attention to problems of learning and intellectual development; and, second, because each of these professions is suffering from its own shortage.

A true shortage, it would appear then, can be estimated only on the basis of (1) a thorough analysis of all the essential functions to be performed, (2) studies of the conditions of employment, (3) current utilization of staff, and (4) a careful examination of the labor market. The real question to be answered is, are there enough people available who have the ability and the skills (or who can acquire them) to carry out the essential functions? And if so, are they willing to work under the conditions provided?

A number of changes in the present situation could favorably influence the availability of professional and other personnel. For example, changes contemplated in residential care and in the delivery of community services; changes in methods of teaching and job training modification in methods of management and in utilization of staff. We can hardly expect to solve the present manpower problems without long-range planning; but long-range planning will avail us little if we base it exclusively on current estimates of need. Hence the importance of the second question.

2. Have We Mastered the Techniques of Estimating Need?

In the United States we have not mastered the techniques of estimating current needs, let alone future requirements. The techniques for such analyses are available to us via the computer and by other scientific methods, but the basis on which such conclusions are drawn depend upon the input, such as sound job analyses and a breakdown of each of the functions essential to sound programs for the retarded.

When we have taken these steps, we will have a foundation on which to build an adequate system for computing personnel needs.

Our present estimates of need, and those recorded by the President's Panel in 1962, are astronomical and if taken at face value, are practically unattainable. For example, in 1966 it was estimated that in addition to the approximately 32,000 teachers of the mentally retarded then in the field, some 49,000 more were needed.[1]

In addition, it has been recommended recently that the present number of institution attendants (45,000)[2] be doubled. Since these estimates are based on current job descriptions and concepts, they are inadequate for long-range planning.

Increased use of day care and other community facilities, adjustments in hours of work, modest salary increases, smaller residential units, and the redesigning of some jobs could change the picture radically. Upgrading the attendant's job in residential care, not only in salary but in perquisites and dignity, or establishing a clear-cut function of teacher aide and volunteer service in special education could make a substantial difference in estimating current and long-range needs.

The future development of mental retardation services depends very largely on the leadership provided by the relevant professions. It is important, therefore, to determine how a greater degree of investment can be assured by the several professions and disciplines on which sound mental retardation programs depend: i.e., medicine, psychiatry, nursing, dentistry, psychology, sociology, religion, social work, education, recreation, physical and occupational therapy, and the other health-related disciplines.

As stated earlier, one of the difficulties is that every profession faces its own dilemmas in recruiting personnel, in the dearth of training facilities, in making adequate provisions for compensation and retirement, in distribution of personnel or in other ways. It is clear, therefore, that the support mental retardation services must have from these disciplines will not be forthcoming unless the professional people in them who are already involved in mental retardation provide the necessary leadership.

By and large, the professions essential to the care, education and management of the retarded are becoming more responsive to their needs. But for the present, the major responsibility lies with those in each profession who have a special interest and concern with mental retardation and who recognize that it must take its place in the mainstream of the service professions.

This is no easy task, for since the President's Panel[3] made its report to President Kennedy in 1962, and before that (via the American Association on Mental Deficiency and the National Association for Retarded Children), efforts have been made to present mental retardation as a special problem (as indeed it is). The idea of seeking closer relations with professions that have hitherto shown little or no interest in mental retardation has raised serious questions; i.e., does a "closer relation" mean integration, and does integration mean that problems of intellectual deficiency, cultural deprivation learning and the like will again be neglected by the relevant professions?

In the Annual Report of the Association for the Aid of Crippled Children, for 1954, the author made the following observation:

> "There is a point in the study and interpretation of . . . a condition at which the characteristics peculiar to it have been sufficiently analyzed, recorded and publicized so that its further pursuit may be related to or combined with other similar efforts without loss of identity or support."

As the professions dealing with the mentally retarded seek solutions to their own dilemmas, they must be reminded again and again that the retarded are first of all people; and consequently they need all of the services required by the general population, plus, of course, the special attention that their retardation demands. It is this plus that should be part of the basic training for each of these professions.

Although the present situations in the various professions and disciplines involved with mental retardation differ, they all face the same serious problem of increased demand.

3. What Are the Main Categories of Personnel That Must be Augmented; and What New Sources Can Be Tapped?

Certain generic functions at the administrative and supervisory levels in mental retardation programs could be clarified and bolstered, thus making them more attractive to qualified people from a variety of disciplines. For the group considered as attendants, we should consider taking a leaf from the French educateur, who is an amalgam of the cottage parent in children's institutions, teacher, counselor and group leader.

The Russian feldsher, 4/ an assistant to the physician, is another model who might well be studied as an example of how personnel with less than full professional training can be highly useful under supervision in carrying out certain carefully defined professional functions.

Since professions essential in mental retardation are fully engaged in meeting their own problems, it would be unrealistic to expect them to take on the additional burden of recruiting and training personnel specifically for service to the mentally retarded. They are, furthermore, deeply involved with the knowledge explosion in their own fields and their accompanying technical developments. Hence, to achieve a better rapprochement, we must relate mental retardation to problems and issues central to their concerns and bring it into the mainstream of their thinking and planning.

In lieu of asking medical men, psychiatrists, psychologists, educators and others to modify their objectives or divert their major interest to mental retardation, we can challenge them to give full consideration to scientific issues central both to their concerns and ours, by concerning ourselves with such topics as:

(1) Developmental problems in prenatal and postnatal life;

(2) The learning process and blocks to learning;

(3) Environmental factors and influences in personality and intellectual development;

(4) Methods of integrating the manifold contributions of several disciplines in order to deepen and broaden our comprehension of the total life process.

A pursuit of these objectives in research, teaching and practice might well develop a new perspective for the behavioral sciences. For example, the knowledge and wisdom required to understand human aberrations more fully will not emerge from any one discipline, but from the contributions of many scientific discoveries.

In this context, biology must be regarded as a behavioral science because it is concerned with the growth of all living things. The marriage of biology and chemistry has brought us close to unlocking the secret of the origin of human life. Perhaps now a partnership between biology and other behavioral sciences could result in new findings about the origin of life and the many deviations that are manifest in it.

The future of behavioral science may well depend on those professional people who are willing to devote time and energy not only to their own disciplines, but also to the relation their discipline has to others. It appears to me that the key to integrating the basic knowledge of human life lies not so much in exploring the relationship between and among the relevant sciences, per se, but in a study of how each relates in its own way to the life process as a whole.

The purpose of this apparent departure from the central theme of how to solve manpower problems in mental retardation is simply to emphasize that the behavioral sciences and the "helping professions" provide the main leadership in helping us to discover more about the nature of mental retardation, how effectively to care for and teach the retarded, and eventually how to aid them in relating to society. In this context, those training for the "helping professions" should be provided with opportunities to carry on field work jointly, thus creating and developing an interdisciplinary training experience in working with the intellectually handicapped.

The university-affiliated training centers in the United States, of which there are now 18 in various stages of development, recognize the importance of this type of training and are actually founded on an interdisciplinary philosophy. Additional help is needed from federal and state funds and from the private sector to insure an increasingly large number of training fellowships.* The entire scientific pool must be increased if more qualified personnel are to be available for mental retardation services.

As the pool enlarges, the American Association on Mental Deficiency, the National Association for Retarded Children and representatives of appropriate scientific organizations with interests in mental retardation must do some practical, down-to-earth planning with those responsible for professional training, for many medical and social work students, as well as those training in other relevant professions, have no practical clinical experience with the retarded.

The main supply of professional leadership for mental retardation will continue to come from the professional and scientific pool, but where shall we look for the staff upon whom we depend for daily face-to-face relationships with the retarded? Teacher aides, personnel for residential and community facilities, recreation leaders, workshop instructors and the like are essential to the care and training of the retarded. To meet this demand several sources suggest themselves: the educable retarded; the high school dropout; retired persons and those undertaking a second career, particularly competent mothers whose children are grown; and of course, volunteers from a variety of age groups.

---

* Following the Banff Conference it was noted that the U.S. Federal Register for June 27, 1969, reported $8.3 million available for grants to state and local governments for staffing mental retardation facilities.

Good and bad experiences have resulted from employing retarded people to work in residential and community programs. Success depends on careful selection of candidates, adequate training and good supervision; in fact, these are the keys to successful job placement for anyone working with the retarded.

Many retired people have shown that they can be effective in working with the retarded. In the United States, the Foster Grandparent project under the poverty program worked exceedingly well, and it is unfortunate that lack of funds has substantially reduced it. For this project, grandparents, essentially retired people, were employed for modest remuneration to visit children in institutions on a regular basis, take them for walks and recreational outings, read to them and act as friends and counselors. These functions can, of course, also be carried on by a corps of volunteers if there is sufficient leadership and initiative to organize and conduct such a program.

Among the half million young people who drop out of high school in the United States each year, a good number have above-average ability. In 1966 a study showed that in an analysis of 21,000 high school dropouts, 11 percent proved to have better than average ability. Obviously, some of them could be trained for useful service.

Women who find themselves with time on their hands when family duties are no longer demanding are another available resource. Many such women have a college education and professional experience, but they need to be informed, challenged, trained and placed.

It was recently reported [5/] that more than 30,000 medical corpsmen leave the military services each year and that relatively few find comparable employment in civilian health care. The problem seems to be that few jobs that carry the status and degree of responsibility found in the military are available to them. Here, then, is a substantial pool of well-trained personnel available for positions in mental retardation and mental illness. Adjustments would have to be made in job structures and salaries to accommodate them, but little or no improvement in our manpower shortage will occur until that is done.

To employ the retarded, retired, second career people and volunteers effectively, it is often necessary to redefine and even to redesign jobs to fit the skills, the experience and the schedules of those desiring employment. I doubt that this has been done to any appreciable degree in mental retardation. As Darrel Mase, Dean of the School of Allied Health Professions, University of Florida, has often put it, [6/] we need better "mindpower" in tackling our manpower problems. This suggests the fourth and final question.

4. What Can Be Done To Make the Challenge of Mental Retardation More Compelling; Recruiting More Effective; Relations With Essential Professions Closer; and Personnel Now in the Field More Productive and Secure?

At least three major steps must be taken if we are to attract more and better qualified people to the field of mental retardation.

The first of these is to get mental retardation more firmly established in the mainstream of scientific training, research and practice, as has been discussed in the foregoing pages.

The second is to establish clear-cut and definitive generic functions at the administrative, management and supervisory levels. The incumbents of such positions might have any number of different professional backgrounds--medicine, social work, psychology, or education, but should also have common elements such as some academic content on mental retardation and some practical experience with the retarded. They would be eligible for their leadership position after an orientation course in the specific setting in which they were to be employed for administrative and/or supervisory positions in residential units, in community facilities, including day care, and in state or local programs. Their skills should be in planning and coordinating, community development and in supervising and training staff.

The third major step that must be taken is perhaps the most important. It has to do with the personnel who carry the day-by-day responsibility for the intimate face-to-face care and training of the retarded in residential settings, in community facilities and in any situation where a close relationship is required on a continuing basis. In most residential units these employees are called attendants. They carry the heaviest responsibility in one sense, but receive the lowest rate of pay, and are generally low on the prestige totem pole.

Theirs are the jobs that most need redefining, intensive study and a far higher status--both from the point of view of prestige and salary. Those who hold these posts need intellegent and stimulating supervision, a greater sense of their own importance and dignity, and a higher status that results from an up-grading of their jobs. Their major functions are three-fold: (a) teaching those activities that are essential for daily living, i.e., helping the retarded child or adult to learn or improve his skills in dressing, eating and toileting; (b) teaching the retardate fundamental work and play activities; and (c) building on the foregoing by helping the retardate acquire as high a degree of socialization as possible; i.e., showing him how to live and work effectively with other people. The importance of the latter has been demonstrated in recent studies[7] which indicate that socialization may be more important for the training of the retarded than the learning of mechanical skills.

Candidates for this type of position should have reasonable emotional stability, patience and a high degree of self-discipline. They should be able to work successfully with others and possess some inventiveness and ingenuity. The training provided for them should include basic content on human behavior, with emphasis on the retarded, on analysis of major programs including various methods of care, and on the limits and potential of different levels of intellectual competence.

Candidates for such positions could be given either one or two years of training that encompasses both academic and field work. Those who successfully complete such a course would then be eligible for service under the supervision of more experienced personnel.

Those who acquired this training should be able to work effectively with individual retardates and with small groups and be able to supervise volunteers, college students, and other personnel less experienced than they are.

At the end of a year of successful work in a recognized agency, the trainee might be awarded a certificate testifying to his completion of the academic and field work required and 12 months of practical experience. He would then be eligible for advancements and eventually for a supervisory position.

One of the criteria that Darrel Mase uses for training and testing personnel at this level is their ability to take independent action. This is an important criterion. The personnel discussed here should be able to act in emergencies in much the same manner as an intelligent and experienced camp counselor; but more importantly, he should know when and how to refer an individual for attention or a service he is not equipped to provide himself. The basic functions performed will always be needed, regardless of the future of residential care.

It is difficult to affix a title to this type of position, yet this is important both to the staff person involved and to his fellow workers. Most of the titles that come to mind are already used by professional personnel and those remaining seem unimaginative and prosaic. Staff Associate is nondescript; Mental Retardation Specialist is too professional; Interne and Fellow have been preempted by the medical field. Mental Retardation Aide is a possibility; but perhaps Staff Specialist in Mental Retardation is a better description.

It is also possible that with some variation in the basic training, by emphasizing emotional disorders and providing field work in appropriate settings, staff specialists could be trained for work with the mentally ill. Naturally, no plan of this kind can be carried out without funds and without an enormous amount of work by civil service commissions, state legislatures and professional groups. There are no easy or inexpensive answers to any manpower problem.

Community and junior colleges could be highly useful for training staff specialists. If they are to undertake such a program, however, they will need the full and active cooperation of the national organizations in the field of mental retardation and the appropriate educational groups. Furthermore, we will be unable to meet and solve these problems without the full moral and financial support of our respective governments.

This conference is concerned with establishing priorities; and priorities mean making choices. In our society we need a clear statement of national policy with respect to the priorities in areas of human welfare and human need, for surely the "trumpet hath an uncertain sound" at present.

The choices to be made are sharp and clear: If we cannot do everything that our society desires to do, where shall we place our major emphasis? On inner man or outer space? On domestic problems or on policing the world? On conservation of human resources or on building an all-powerful industrial-military complex designed for destruction?

I confess to moments of depression and discouragement when I realize how much depends on that relatively small number of devoted men and women who have concern; who have no "angles" and no axe to grind, except to do their utmost to insure a decent world for the future. The future quite literally is in their hands.

There is an appeal at once scientific, humane and emotional in the challenge of the retarded, for it is a challenge to train, to salvage and to prevent. The practitioner who converts human liabilities into assets is performing to a high order a service to all mankind.

There is great promise in the cooperative endeavor of Canada and the United States in devising new approaches and solutions to the manpower problems in mental retardation. I hope that all of us look upon this meeting as an auspicious beginning for a fruitful partnership.

REFERENCES

1/ U.S. Office of Education Report of HEW

2/ New Patterns in Residential Services for the Mentally Retarded.
Editors, Robert B. Kugel, M.D., and Wolf Wolfensberger, Ph.D.
Published by the President's Committee on Mental Retardation,
Washington, D.C.; 1969.

3/ A National Program To Combat Mental Retardation. Report of the President's Panel on Mental Retardation, 1962. U.S. Government Printing Office.

4/ New England Journal of Medicine, April & May 1968 issues.

5/ Washington Report on Medicine and Health, June 16, 1969, No. 1146.

6/ Position paper prepared for Banff Conference by Darrel J. Mase, Dean, School of Allied Health Professions, University of Florida, Gainesville, Florida.

7/ Bernard Posner, Deputy Executive Director, President's Committee on Employment of the Handicapped, Washington, D.C.

BIBLIOGRAPHY

"A Method for the Study of Manpower Needs," Albert Hanwell and John E. McManus, Child Welfare (Journal of the Child Welfare League), April 1969; 44 E. 23rd Street, New York City, New York.

"The Impact of Automation and Technological Change on the Employability of the Mentally Retarded," by Russell A. Nixon, New York University. (Draft of forthcoming article.)

Position papers prepared for Banff Conference by Cyril Greenland, Patrick Doyle, M.D., and Darrel J. Mase, M.D.

"The Growth and Development of Allied Health Schools," by Darrel J. Mase, University of Florida. Paper given at the 64th Annual Congress on Medical Education, the Council on Medical Education of the American Medical Association.

"Special Education for the Mildly Retarded--Is Much of It Justifiable?" by Lloyd Dunn, Former Director, Institute on Mental Retardation and Intellectual Development, George Peabody College for Teachers, Nashville, Tennessee.

GENERAL SESSION

DISCUSSION HIGHLIGHTS

The various problems arising from manpower needs in mental retardation have one basic aspect in common: a lack of hard data upon which to base priorities for action. It has not been established whether shortage of qualified workers in mental retardation is due to unequal geographic distribution of personnel, to self-imposed isolation by the various services that results in staff duplication, to lack of training facilities, to the unattractiveness of some vocational levels and roles in present service structures, or to the possibility that most staff positions in the present structures force personnel to work at levels either above or below their training and abilities. In short, there are a variety of alternative approaches.

Traditionally, we request more money from governments to hire more personnel in order to perpetuate our present "shotgun" approach to manpower problems for the care and habilitation of the mentally retarded. In order to gather data to facilitate attempts at solving the manpower problem, full implementation of available epidemiological techniques is needed to break down the gross "statistics" now available into smaller, more meaningful indicators of the problem parameters. Analysis of each job and inter-role comparisons are necessary to determine if common functions exist in some of the present apparently independent vocational roles.

Analysis of present service structures, via cost-effectiveness procedures handled by "outside experts," would force us to state our goals and should result in procedures for eliminating waste of manpower. Productivity and relevance of present educational processes must be questioned. Attempts should be made to determine how vocational satisfaction can be maximized at every staffing level in our service structure, and what is needed to open the present "closed shop" for established vocations at the managerial level. Encompassing all of the foregoing suggestions is a need to relate to the consumer and to evaluate the effectiveness of what we are doing; in fact, to compare all the above data to what is found to be needed and to provide the new roles, careers, training and satisfaction necessary for solving these problems.

At the professional level, the diagnostic care and treatment services for the mentally retarded have created many specialized roles. A high level of specialization and the resultant professionalization phenomena often result in "vertical" vocational interests and very little interest in or cooperation with other specialties. Teamwork is desirable, but which of several alternative models of cooperation should be implemented? Would interdisciplinary training at the undergraduate level result in increased understanding of other persons' roles and higher levels of cooperation? For instance, should medical students be encouraged to "specialize" in general medicine? In the mental retardation area, would the client benefit from increased cooperation between the school and medical facilities available or would the focus of the individual s problems become blurred as a result of conflicting ideologies? Should the "best model" suggest cooperation among distinct roles; i.e., should medical personnel handle the diagnosis and other professions be prescribed as required?

Some revision in educational requirements for many positions should increase the human resource pool from which staff can be selected. Also, if the workers already in the field were able to determine and verbalize the reasons they are in the mental retardation area, a public relations program directed to the young adults of our society might be built on these motivating ideas.

Another facet of staffing problems involves the personnel who lack formal training. Because of the meniality associated with the tasks in which they are involved, reference to them usually connotes some lower level of functioning. However, the shortage of staff in these positions points out the need for reevaluating these roles. Supportive staff members are essential to the success of any program and an adequate supply of well-trained people must be provided and maintained. The possible channels through which such a goal can be attained are in the institutions of higher education, in-service training, concerted public relations programs, revision of role structures, and the establishment of definite career boundaries. Any of these approaches will encounter resistance, but these obstacles have been overcome in some instances. These revisions in the service structure must then be communicated to the most abundant sources of personnel such as high school graduates, volunteer workers, and indigenous persons.

It is possible that both professional and supportive staffing problems will be alleviated through shifts in current emphasis away from physically isolating the mentally retarded population and special treatment programs. Perhaps the need for more professional staff stems from the fact that the professionals who serve the general population do not serve the retarded population and vice versa. To obtain the numbers of professionals needed to serve the retarded adequately, staff will have to be attracted away from the higher compensation and status that results from serving the general public. In the present educational structure the needs of the retarded are met by resources separate from those of the "normal" population. The question that arises is, "Why duplicate?" Why shouldn't the retarded use those services which can benefit them and rely on "special services" only when the public resources cannot satisfy their needs?

Another problem arises at the management levels of public services. In most situations personnel are promoted to levels of incompetence; i.e., when they have reached a level where they are not competent, they are not promoted further. Unfortunately, most administrative positions are filled via this route. The resultant "position protection" inhibits growth of staff and programming to the point of public alarm, at which point a general reshuffling occurs and the cycle begins again. There is a definite need for management training programs that are independent of present institutions but do not exclude experiences in the eventual service area.

Encompassing all the foregoing areas is the need for evaluation processes that can objectively review the effects of the present situations and suggest the alterations needed. If a business model is employed, "profit" motives must be built into the system, experts must be built into the system, experts must be trained for evaluation (cost accountants) so that the end product and its costs must become vital concerns. Hopefully, governments will then be able to assign funds on a priority system based on hard data. If effectiveness is stressed, program modification will follow evaluation rather than the whim of the group in power. The system must start answering the needs of the client, not the needs of the profession; it must determine what the community needs and must strive to provide these services and not force the public to accept only what is at the moment provided.

THEME I

PROBLEMS IN TRAINING PROGRAM DEVELOPMENT

Problems in Training Program Development

Introductory Statement

Darrel J. Mase
University of Florida

Introduction

This position paper will be directed to seven general points: (1) communication problems between disciplines; (2) communication problems between training programs; (3) communication and coordination between universities; (4) coordination between universities and communities; (5) coordination between universities and government; (6) barriers to the development of new and innovative programs; and (7) techniques for evaluating activities, including (a) programs, (b) time allocations of faculty, (c) job descriptions for personnel involved in coordinated programs, (d) utilization of personnel, and (e) outcomes.

These topics demand attention to the business of working together, to which there are two primary aspects: (1) communication between all those who have a role to play in the desired end result, and (2) cooperation if so indicated, with collaboration as progress is made toward the desired end. We must remember that interdependent cooperation is a natural counterpart of specialization. This principle is basic to the social sciences, for the more specialized individuals become in their own work, the more interdependent they are likely to be for a wider perspective. This verbal paradox suggests greater need for cooperation even though it might be more difficult to attain. The business of various individuals and institutions working together has often been referred to as "teamwork," which means simply a close, cooperative, democratic kind of action by the various individuals and institutions working for a common goal.

We should not confuse the concept of the roles of individuals and institutions in the "communication" and "coordination" processes. John W. Gardner (1968), former Secretary of Health, Education, and Welfare, in his latest book, No Easy Victories, states, "I have had ample opportunity to observe the diverse institutions of this society--the colleges and universities, the military services, business corporations, foundations, professions, government agencies and so on. And I must report that even excellent institutions run by excellent human beings are inherently sluggish, not hungry for innovation, not quick to respond to human need, not eager to reshape themselves to meet the challenge of the time." Gardner continues, "I am not suggesting a polarity between men and their institutions--men eager for change, their institutions blocking it. The institutions are run by men. And often those who appear most eager for change oppose it most stubbornly when their own institutions are involved. I give you the university professor, a great friend of change provided it doesn't affect the patterns of academic life. His motto is, 'Innovate away from home.'" Gardner adds, "We are going to have to do a far more imaginative and aggressive job of renewing, redesigning, and revitalizing our institutions if we are to meet the requirements of today." This is the charge to which we must respond if we are to "communicate," "coordinate" and remove the "barriers" that are our "problems."

My observations over the past several years have led me to believe that the smugness, the protection of vested interests, and the resistance to change by professional groups are not the fault of the professional person per se, but the fault of the educational system. When we ask the "in" group to solve their own problems, it is difficult for them to be objective. Most states have had federal funds in the past 10 years for separate planning for first, mental health (in many states this includes mental retardation), then mental retardation, vocational rehabilitation, heart, cancer and stroke, and now comprehensive health planning. Often the same heads of state agencies serve on more than one of these planning groups. Seldom are they without vested interests and thus could perhaps be more objective when asked to determine what the respective states should do in these separate but overlapping and closely related areas.

Planning for change is frequently beset by problems. There may be apathy and indifference to the problem, or there may exist critical awareness of the problems but too many people having too much vested interest, thus possibly allowing rapid changes in isolated places, but not bringing about change for society.

Gardner (1968) says, "It is apparent that we do best when the problems involve little or no social context. We're skilled in coping with problems with no human ingredient at all, as in the physical sciences. We are fairly good at problems that involve the social element to a limited degree, as in biomedical research. But we are poor at problem-solving that requires the revision of social structures, the renewal of institutions, the invention of new arrangements." This latter technique is primarily what is needed in coping with the problems in "training program development" for the mentally retarded. Problems in this area are so complex that solving them might be threatening to what many of us were taught was to be found outside the sanctuaries of our educational institutions. It is so much easier for us to live with things as they are than to consider making substantial changes. Therefore, as our past reinforcement training has demonstrated, social change necessitates a learning process for all of us. Re-education of even our educated practitioners is essential if we are to accept new programs, new values, and new procedures.

The lack of effective communication is the root of many of our major problems and social ills, whether they be in the home, the institutions, the community where we work, the state, the nation, or the world. We need to remember that anytime we point one finger at anyone else, three of our fingers ought to be pointing at ourselves. Each individual, profession, or institution, before becoming too critical of another individual, profession, or institution, should confront itself in a mirror and take a good, careful "look-see." What he will see may be the cause of the difficulties in "communication," "coordination," and removing "barriers" that do not permit the changes necessary in order to extend the quality and quantity of services to the mentally retarded. Booker T. Washington once said, "Let us be as separate as the fingers and as united as the fist." Let us consider mental retardation with this attitude of separate strengths and united power.

Professions and institutions are somehow like nations in that none can go it alone anymore. We must struggle to think as others think, to perceive as others perceive, if we are to understand them. This is not only the heart of much good therapy but also an effective method for approaching the problem. In a 1959 newspaper article, Dr. Howard Rusk told, in some detail, of a little boy 12 years old who was blind and who was so "out of touch with reality" that he was not allowed to continue in any school. In talking about his blindness with a psychiatric social worker he said, "If wishes could come true, I'd wish I could see. But if I had only one wish, I wouldn't waste it on wishing I could see, I'd wish instead that everybody could understand one another and how a person feels inside." If I had one wish for accomplishing our objectives and goals in behalf of the mentally retarded in Canada and the United States, yes, indeed in the world, it would be that "everybody could understand one another and how a person feels inside." If we can admit another individual's perceptual world into our own, this might well permit us to "communicate," "coordinate," and remove "barriers" more effectively.

(1) Communication Problems Between Disciplines

Our higher educational systems with their various independent departments, schools and colleges on a university campus have a tendency to teach disrespect and perhaps suspicion of disciplines other than their own, even though "the others" have knowledge and skills with which they must coordinate in order to determine a program of treatment, care, education and rehabilitation for the mentally retarded. Universities are among the most archaic structures we have in our society; the ivy on the walls has been there a long time. Specific disciplinary programs are built vertically rather than horizontally. The professions that must merge their knowledge and skills are taught to be smug and secure about their own discipline rather than being taught about the limitations of their speciality and a proportional humility for what they do not know.

This perceptual distancing is a function of both the knowledge explosion of our age and the absence of adequate structures for teaching students from various disciplines who might profit from learning together and not just in the same place.

Health centers with schools of medicine, nursing, dentistry, pharmacy, and health-related professions are being developed in one complex to eliminate the suspicion and jealous hostility between disciplines. The philosophy behind such complexes is that if people train together, they will be better able to work together. But even given such administrative structures, with the physical limitations of classrooms and laboratories constructed as they are (there hospitals have room for no more than the second and third year medical students, the intern and several residents, and the professor), there is hardly room to bring other disciplines into the hospital room, classroom, and laboratory for the combined clinical learning experiences of the many disciplines.

Similarly, there seems to be an unwritten law that undergraduate students cannot learn in the same setting as graduate or advanced professional students. We have also found that even though those from the health professions get together into some learning experiences, there is often no way to bring the student in special education, clinical psychology, speech pathology, rehabilitation counseling, sheltered workshop programs, and various other disciplines related to the treatment of the mentally retarded into this connom learning experience, except in isolated instances.

The ways we have structured learning situations are among the basic reasons for "communication problems between disciplines." If we are to prepare professionals oriented toward meeting the comprehensive needs of the patient, client, or student, we must, in our education and continuing education processes, foster many more opportunities for horizontal teaching across the many disciplines related to mental retardation, rather than concentrating solely on vertical teaching of a specialty.

(2) Communication Problems Between Training Programs

Gardner (1968) stated, "Much education today is monumentally ineffective. All too often we are giving young people cut flowers when we should be teaching them to grow their own plants. We are stuffing their heads with the products of earlier innovation rather than teaching them how to innovate. We think of the mind as a storehouse to be filled rather than an instrument to be used." Most training programs follow the archaic patterns described while a few courageous others are attempting to break the tradition by viewing students' minds as "an instrument to be used." When the students from these two divergent schools of thought practice in the same department of medicine, physical therapy, or special education, the resultant conflict of educational philosophies can adversely affect the students, patients, clients, and pupils they serve, and yet produce no means or mechanism of resolution for the conflict.

Other inputs also create communication problems between training programs. Gardner (1968) addresses one of these inputs when he suggests, "Love of learning, curiosity, self-discipline, intellectual honesty, the capacity to think clearly--these and all the other consequences of a good education cannot be insured by skillful administrative devices. The quality of the teacher is the key to good education." Teachers in the various "training programs" vary greatly with the result that the graduates vary greatly. And yet they are all graduates, some insecure because they know they are less well trained, some arrogant and hostile because they are better trained, and there are no mechanisms available to recognize their additional skills.

Concomitantly, our licensure and certification requirements in most disciplines are far behind our knowledge about what is needed by the different disciplines. This standards lag makes curriculum adjustment difficult in some instances, resisted in others, and impossible in still others.

As if this lag were not enough, there is also an overlapping and duplication about each discipline's rights and privileges. These differences are greater in some academic settings than in others. When students come together from these various settings and their varying ideologies to relate to the child who is mentally retarded, their differences, which took 4 to 12 years of preparation to establish, may do more harm than good to the child. Not all academic programs in any discipline should be identical, but there should be more commonalities than now exist. The student should have been taught that upon graduation he will have only enough preparation to begin his education, which, particularly for a professional, is a lifetime process of learning, weighing, evaluating, and re-evaluating all the alternatives.

(3) Communication and Coordination Between Universities

We now add another component to "communication," namely "coordination." Most universities and their governing bodies have established patterns in their respective states, through which they can communicate and coordinate their activities. We also struggle with efforts to do this on a regional basis by which administrative structures as the Southern Regional Education Board (for the Southeastern states) and the Western Interstate Commission for Higher Education (in the far West). However, civic pride and personal ambitions sometimes channel us unwittingly to duplication, to several weak programs rather than one strong one, or to a relatively few students with a weak faculty in two or more programs when one planned situation could handle the several programs with better staff, more laboratory equipment, more comprehensive library facilities and more adequate support from the administration.

This problem does not exist in only one state or region. We have no devices for determining who does what on the national level. How many quality academic programs we need and can afford in each of the fifty states to prepare teachers for the mentally retarded deaf, the mentally retarded blind, sheltered workshop administrators for the mentally retarded, and other possible disciplines has never been determined. Consequently, we need to confront the following questions: Should archaic geographic lines, as determined by borders of states established 150 to 200 years ago, determine which universities should meet manpower needs? Should there be more interchange of students between universities so that many students might get their general education in one of many institutions and their specialized knowledge and skills for the discipline of their choice in a different, stronger academic program? What administrative and organizational devices can be established to ensure efficiency and quality of education in the various disciplines in the many colleges and universities? How can Canada and the United States join hands in these efforts?

As previously stated, we must remember that as a people we are not very effective as problem solvers, since this requires revision of established social structures. Living with the status quo provides a much more comfortable way of life than attempting social change. We have become very effective at scientific and technical advancement while remaining fearful and complacent in respect to social changes. For example, we still have problems in respect to the proliferation of technical schools, vocational schools, junior colleges and universities, an undefined proliferation with only minimal specification as to which institutions should do what things for which students.

"Communication and coordination between universities" simply means to imply good management. It would not be good management for General Electric to have three plants in one state producing a specific type of light bulb, if one plant could produce sufficient bulbs of this type, cheaper, and of a higher quality. Similarly, it is good business for colleges and universities to determine what numbers of "quality light bulbs" are needed to serve the mentally retarded in the various disciplines and then to see that their best judgments are implemented.

(4) Coordination Between Universities and Government

In the United States a large proportion of support for higher education comes from the federal government. This has been true for many years in specialized areas of medicine, dentistry, agriculture, and others.

Recently, there has been greater support for special education. The report of President Kennedy's Panel on Mental Retardation, which was prepared with recommendations for action, brought much new legislation and additional dollars for training programs for the mentally retarded at all levels. The President's Committee on Mental Retardation, which was established in 1966 by President Johnson, has kept the needs of the mentally retarded before the public and has been responsible for further support.

However, we have never been able to meet all the needs. This is true in part because we have found it difficult to close the gap between what we know and what we are able to apply. While the universities and the federal government seem to work cooperatively, universities still find that there are monies available for preparing professionals in one of the many needed disciplines, but not for others. The view of comprehensive services for the mentally retarded tends to generate an unfinished jigsaw puzzle effect with enough pieces missing to unnecessarily obfuscate the total picture. The child who is mentally retarded does not have the opportunity to function at his greatest potential in this type of environment.

Some universities view the many federal agencies that fund parts and pieces of this puzzle as being in competition and in fact in opposition to their desired objectives. The funding of programs by the federal government acts as a patronage system, at times funding programs in a locale that is perhaps not the best setting for that type of program. Each state feels it should get back approximately the same number of dollars that it sends to Washington. Frequently, the mobility of our society does not receive proper consideration.

Since universities need money, individual professors, departments, and colleges will at times accept money for specific training projects because they are asked to do so by the federal government, or because they look better in the eyes of their own administrations if they can show their ability at federal dollar-getting. University administrations seldom have devices for determining the desirability of the respective program for that respective professor, department, or college. However, "communication and coordination" are improving between the universities and the government, as there now is much more planning for effective use of the tax dollar and much more decentralization of federal funding to the state and regional offices. However, we still must find more effective ways of relating the federal and state governments to one another and to the universities.

(5) Barriers in the Development of New and Innovative Programs

"New and innovative programs" are often not new to society but only to the individual espousing them. Research on new techniques is often done by an individual or small groups in the university. When the study is completed, a paper reporting the research is finally published a year to two after the completion of the work, and by this time a dozen other places already have the same "new and innovative" ideas. In addition, the paper seldom offers procedures for implementing the "new and innovative" ideas, with the result that the gap between what we know and what we apply widens. What we need are research grants that establish patterns indicating how to apply new knowledge in the treatment, care, education, and rehabilitation of the mentally retarded.

We still tend to establish programs in terms of what the literature of the past tells us rather than what the knowledge of today and the trends for tomorrow reveal. No longer do we have time or need for philosophizing in committee meetings and conferences to determine how to meet manpower needs for the mentally retarded. What we must do is apply the concepts and knowledge we have. The time for action is now; we must move but remain capable of altering our course as we discover better procedures.

We should think in terms of mindpower utilization rather than of manpower utilization. Manpower utilization represents what we have been doing: physical therapists doing what physical therapists now do; nurses doing what nurses now do; dentists doing what dentists now do; teachers doing what teachers now do. Mindpower implies using the knowledge, skill, and capacity for independent thinking of our health and education personnel for those things for which they are uniquely qualified and delegating to others some of the responsibilities previously assumed by jealously guarded, vested interests. Half or more of those in the health and education professions have bachelor's, master's, or doctor's degrees. This makes the labor market lopsided in respect to the duties to be performed, because those with advanced degrees frequently perform tasks that do not require their knowledge, skill, and capacity for independent action. Nearly all of those in the classrooms teaching the mentally retarded must have bachelor's or master's degrees. Is this truly necessary? What about using teaching assistants, aides, and volunteers?

The following table offers an alternative plan for preparing personnel in the health occupations.

TABLE I

A Numerical Representation (0 - 4+) for Personnel in the Health Occupations of the Amount of Knowledge, Skill, and Capacity for Independent Action as These Relate to Four Levels of Education and Training.

Level of Education	Knowledge	Skill	Capacity for Independent Action
I - Doctorate	4+	4+	4+
II - Bachelor's and Master's degrees	4+	4+	2+
III - 2-year College Associate degree	2+	4+	1+
IV - On-the-job, Vocational, and Technical Training	1+	4+	0+

Mindpower utilization implies that the individual with advanced education and training will supervise and direct the activities of the individual with less training. The physical therapist at Level II works under the prescription and general supervision of a physician. The physical therapy assistant (approved by American Physical Therapy Association and permitted to have membership in the association) would be at Level III and work under the physical therapist; the physical therapy aide trained at Level IV would function under the physical therapy assistant. There might well be four or five individuals at Level III and IV under each Level II person. Within this approach the physical therapist becomes a manager of doers rather than only a doer; quality is maintained while quantity is multiplied. This delegation of responsibilities would lead to efficient use of mindpower, would maintain quality services, and would improve the lopsided distribution of those in the health occupations and professions. This same principle, but perhaps not to as many levels of functioning, ought to be applied to special education for the mentally retarded as well as to all public school education.

In closing, let me reiterate that we must find ways to improve communication and coordination between disciplines, training programs, universities, and universities and government, and between the federal, state, and local governments. We must recognize the barriers that exist in the development of new and innovative programs, but we must further recognize that the gap between what we know and what we apply continues to widen. The universities must move to serve the communities in their many areas of interest, as they have been doing in agriculture for many years. It is now high time for us to do for people what we have done for animals and plants. Even though it is less difficult to change the breeding, feeding, and living habits of animals and plants than it is of people, at this time in our history it is more essential that we effect the necessary social changes.

References

Gardner, J.W. (1968) No Easy Victories, Harper and Row, New York.

Rusk, H.J. (1959) "Light of Darkness," New York Times (January 4).

Discussion Highlights

Professional roles and services in mental retardation are undergoing a necessary and predictable evolution: whereas for the past 10 to 15 years services and training facilities were specialized and segregated, the trend for the next 10 to 15 years seems to be synthesis or gradual integration of facilities and personnel serving the mentally retarded in order to achieve maximum benefit from all services. Although segregation has established services to meet pressing needs, duplication and isolated specialization has also created inefficiencies.

The turning point in the evolutionary process can clearly be seen in the following statement* about programs for special education of the mentally retarded:

> It is essential that programs of special education for the retarded move from a separatist self-contained program into the mainstream of the educational process.
>
> Special class programs, particularly for the EMR, should be immediately and intensively reevaluated with the following objectives in mind:
>
> (1) To utilize the total resources of the school for the education of EMR children. This could result in fewer special classes, and, in the long run, the elimination of almost all such classes as they are now structured.
>
> (2) To plan more intensively with personnel outside the field of special education for EMR children in order that total school resources may be utilized for the benefit of these children, including such areas as work-study programs, counseling, etc.
>
> (3) To redirect teacher education programs to give special education personnel, regular classroom teachers and school administrators a broader perspective toward the education of the mentally retarded. The teacher education program in special education should give more emphasis to the training of resource personnel to assist all school personnel with the educational problems of the retarded.

---

*This is a policy statement formulated by one of the groups reacting against the general group discussion.

(4) To stimulate state or provincial agencies and colleges and universities to encourage school districts to examine their programs and to initiate pilot or model programs that will extend their total resources to the retarded child.

(5) To reexamine manpower requirements in relation to program changes.

The impetus behind the interdisciplinary approach to professional training was the idea of the specialized generalist who, while well versed in his own discipline, can and does use related services. Interdisciplinary activity is spreading from these disciplines outward to include those who have only intermittent contact with the mentally retarded: law, administration, dentistry, general practice, etc. Students in these areas felt that while course content was important, the most effective means of fostering interdisciplinary cooperation was exposure to the issues through training clinics or recreation programs for the mentally retarded. This move to practicum training would increase the status of the field supervisor and force closer cooperation between the university and community services.

The most frequently cited example of misuse of staff was the promotion of professional staff to administrative roles. While the administrative position gives the professional power to change systems, it also robs the field of valuable service personnel and often creates an inefficient and biased administration. To avoid this problem, it was recommended that either administrative options be incorporated into professional training, or that special orientation to mental retardation be given to students of administration. The most desirable, but difficult to implement, solution would be a hybrid public health administrator, specializing in administration with a mental health cognate (e.g., mental retardation, special education). In the meantime, policies should be developed that will allow the experienced professionals power to effect change without being burdened with administrative responsibilities.

In assessing the performance of services, it might be most useful to examine the major modalities of prevention, early detection, education, and habilitation rather than professional roles. Since habilitation has the least entrenched professional structure, it was chosen as a model for speculating about functional analysis. It was also recommended that services required be studied in the light of existing personnel. The areas deficient in service could then be used for experimental models of care. (The Ontario Hospital School's [MR] recent project is a good example of how the introduction of new models in designing training programs for the personnel is likely to fulfill the roles as defined.) The evaluation of such experimental programs would then provide a basis for further change.

In-Service Training

Positions based on functions should provide job identity (status), responsibility and mobility. Mobility is seen as being paramount when employing the "untrained." Promotion on merit, experience and in-service course credits must be encouraged so that new jobs do not become dead-end vocations. The career ladder concept has already been expanded from upward movement to lateral movement: for example, when staff in residence train in educational or vocational units, it would ensure that the man "at the top" of the ladder has depth and breadth of training and experience. This system would be enhanced by offering university/junior college course credits for completion of approved in-service programs. University recognition would lessen the education gap and ease the way to accreditation of the "new breed" professional while at the same time encouraging university students to work in centers for the mentally retarded.

Junior College

The in-service courses mentioned should provide a meaningful practicum section for courses in habilitation. However, to be maximally useful, the junior colleges must work with the facilities they will eventually serve and with the university and government agencies that control certification.

University Training

Universities have recently been soundly criticized for not preparing graduates for the "real world" problems they will have to face. There should be goal-directed dialogue with the consumer of the graduates' services, and with the graduates in the field, so that course content can be made more relevant to the needs of society.

The overriding recommendation was for continued evaluation of courses, programs and roles. A field such as mental retardation cannot afford to harbor "sacred cows" if improved services are to be realized.

THEME II

TRAINING BASIC AND SUPPORTIVE PERSONNEL

Training Basic and Supportive Personnel

Introductory Statement

Cyril Greenland
The National Institute on Mental Retardation
Canadian Association for the Mentally Retarded

Part I: A Synopsis

Theme

"Every kind of worker with the retarded is in short supply."
(PCMR, 1968)

The Situation

Half of all the residential facilities in the United States are functionally inadequate for the care, rehabilitation, learning and growth of the mentally retarded. To bring these facilities up to minimum AAMD standards, a 50 percent increase in professional staff is required. These figures come from the 1968 report of the United States President's Committee on Mental Retardation. There is no reason to suppose that the same estimates cannot be applied with equal validity to Canada and the less wealthy nations of the world.

Over the past 10 years expenditure on general health care doubled in Canada and tripled in the U.S.A., but the effective demand for new and better medical services shows no signs of diminishing. As long as there is a booming demand for medical and paramedical personnel to treat the more affluent and successful members of society it is unlikely that mental retardation--which has low status and prestige--will ever attract enough competent professionals. In this respect, the mentally retarded, together with the indigent, the aged, and the chronically sick, are twice cursed in our success-oriented economy: first for being disabled and second because they cannot respond adequately to the modern miracle cures.

The unpleasant truth is that now and in the predictable future there is no way to expand human resources to meet the need for professional staff in the mental retardation institutions. In fact, within the existing medical framework, the present unsatisfactory conditions and staff shortages are much more likely to deteriorate than improve during the next decade. The solution, as presented in this position paper, will involve dismantling the large decaying institutions, extensive retraining and deployment of staff, and massive investment of public and private funds in distressed areas to strengthen and develop new patterns of community care.

Recommendations

1. Mental retardation institutions might have been purposely built like fortresses in remote and inaccessible places so that they would survive the storms of change. Tenaciously resistant, they defy the often heroic efforts of the staffs to change them. Now there is no longer any alternative but to abandon these institutions and the alienating practices which sustained them for so many years.

Even though it is recognized that rapid transition from institution to community will generate turbulence at many levels, the cornerstone of the new comprehensive community-based services will be the planned dismantling of the large institutions. To avoid resistance, all those concerned with the change must be involved in the decision-making operations. Experienced social planners, as well as mental retardation specialists, will also have to be involved in planning for change and the future.

Starting in one region, on a demonstration basis, the new model agency, preferably under some educational rather than medical auspices, should cooperate with and support, rather than duplicate, existing community resources. The aim should be to integrate the mentally retarded and other handicapped people into "normal" society as far as possible.

2. Desegregation should be the keynote of the new community services. Strengths rather than weaknesses, normality rather than abnormality, must be emphasized in provisions for the retarded. In practical terms, this means that the community should:

(a) Develop and improve the prenatal and perinatal care for expectant mothers who are unable to purchase private medical attention.

(b) Clear slums and provide adequate housing at rents which families with low incomes can afford.

(c) Support nursery schools to stimulate the social, cultural, and intellectual development of children.

(d) Advocate early entry into the regular school system for children with particular handicaps and cognitive disabilities.

(e) Undertake remedial measures for physical defects, visual, auditory, and speech disorders, etc., as far as possible within the school system, by educational specialists.

(f) Recommend that severely retarded and multiply handicapped infants and children be kept at home and supported by domiciliary and day care services. The parents should be given an allowance or reimbursed fully for the expenses involved in providing special home care in place of long-term institutionalization.

(g) Make local provisions for hospital, nursing home, foster or hostel care, when home care is impossible or undesirable. Parents and relatives should be encouraged to continue to visit and care for their severely disabled children. In the absence of parents, life-long guardianship should be exercised by Children's Aid or another appropriate welfare agency.

(h) Encourage experimentation to provide foster homes, hostels, residences and even small village communities for disabled adults, including the retarded. Jean Vanier's L'Arche (Janier, 1969), the Adult Occupational Centre at Edgar, Ontario, and the School at Truro, Nova Scotia, provide models for such developments.

(i) Remember that successful integration of retarded and other handicapped children into the regular school system will require an increasing degree of administrative initiative, flexibility, and sophistication. The movement of psychoeducational specialists in and out of the schools in "home-school-work" projects will be essential. Similarly, retarded adults will also benefit from continued education as much as their gifted brothers and sisters who enter universities.

(j) Support sheltered workshops that have demonstrated that handicapped people can be usefully and productively employed. The next step is to encourage industry, local and provincial governments, etc., to set examples by actually employing retarded adults. The vital bridge to full employment will probably be the "school-work" programs. Consultation with labor unions and employer associations will be a prerequisite for the success of this development.

(k) Foster "normalization" of community programs for the retarded by developing new kinds of professional and subprofessional personnel as well as reorienting the existing professional disciplines such as medicine, education, psychology, social work, etc. Senior educators, psychologists or social workers should be appointed to direct the new community programs and facilitate the transfer of patients from the institutions. Social planners and community organizers will be needed to introduce the new programs and coordinate the efforts of existing ones. Community college graduates and indigenous workers should be trained as youth counselors to work directly with the retarded and their families.

(1) Encourage parents' associations to reformulate their role in order to facilitate the integration of services. They should pay particular attention to the needs and problems of parents in poverty areas who are currently under-represented in the associations.

The National Institute on Mental Retardation in Canada must play a decisive role in providing leadership and direction by initiating and promoting "future-oriented" patterns of service. Although the present needs for the training of personnel must not be neglected, sufficient resources must be reserved for research, consultation and evaluation of new programs. The core service of the institute should be its interdisciplinary information and data center, which should be linked to similar data banks in other parts of the work.

Part II: Needed--A Revolution in Caring for the Retarded

> The majority of the retarded need not medical treatment, but rehabilitation training--so they can use their maximum potential. While every promising research lead should be pursued, and every significant effort in the whole field of retardation should be supported, a truly generous part of the new federal funds ought to be invested in research aimed at helping the retarded lead lives as normal as possible. And more funds should be spent to train people who will, in turn, help train the majority of the retarded (Albee, 1968).

Thesis

The main thesis of this position paper is that the present patterns of services for the mentally retarded are ineffectual and conceptually unsound. The identification, management, education, training and supervision of the retarded who need assistance involve psychological, pedagogical, and social work services rather than medical or psychiatric skill. These disciplines should therefore assume the major responsibility for planning and administering the mental retardation services. They should work in consultation with medical specialists, not the other way around. The cart is now before the horse. Reversing this and putting the horse before the cart will involve dismantling the large hospital schools which function as "human warehouses," retraining and redeploying staff, as well as diverting massive investment of public and private funds into economically deprived areas to strengthen family and community resources. Only in this way, will prevention and cure become a realistic goal rather than a pious hope.

Personnel

Since it is impossible to consider manpower in abstract terms, the first part of this paper is concerned with a review of the logistical problems of current mental retardation programs. The sources to be cited for much of these preliminary data are the U.S. Mental Retardation Planning Reports. One of the best, Miles To Go, from the State of Connecticut (1966) takes a national view of manpower needs for all health programs. Here are some of its main conclusions:

> By 1970 an estimated 850,000 nurses will be required. This translates into at least 100,000 nursing school graduates each year, against today's 33,000 a year.
>
> We need 330,000 more physicians in the next 10 years just to maintain today's ratio of 140 physicians to 100,000 citizens. This translates into 11,000 medical school graduates each year, against today's 8,000 a year.
>
> We need another 600,000 acceptable hospital beds and a minimum of 300,000 more nursing home beds. By 1970, the number of nursing home beds will have to quintuple to meet anticipated demand.
>
> We need to double our current supply of dentists and medical technicians and to graduate 10 times today's annual number of occupational therapists and Ph.D.'s in psychology.

Further examples could be given, but the message is--or should be--clear. To meet current demands for services in the U.S.A. an extra million professionally qualified health personnel are needed. This estimate takes no account of the additional need for specialist personnel in new medical fields, such as heart and kidney machine technicians, etc.

Physicians

The demand for physicians would be even greater without the 40,000 foreign medical graduates comprising 14 percent of the active practitioners in the U.S.A. Almost 7,000 graduates of foreign medical schools (i.e., outside the U.S. or Canada) enter the United States each year. As a result, the supply of licensed physicians in the U.S. is augmented at the rate of 1,400 each year. This represents the annual output of approximately 20 foreign medical schools--a cost benefit to our American neighbors of about $84 million per year.* Dramatic as these figures are, they do not take into account the drain to the U.S.A. of about 300 Canadian physicians each year, the equivalent product of about five of our medical schools.** However, this loss is balanced by the annual immigration to Canada of between three and four hundred physicians. Between 1953 and 1961, 3,815 physicians including 1,764 (46.2 percent) from Britain, migrated to Canada.***

Although the general shortage of psychiatrists is severe, the problem is exacerbated in many parts of Canada and the U.S.A. by their unequal distribution. For example, Montreal, Toronto, and Vancouver are much better served than other areas. New Brunswick, with a population of 650,000 should have 35 qualified psychiatrists; it has but seven. The shortage is just as acute in other areas.

The Psychiatric Team

If the psychiatrists are to serve as consultants rather than as practitioners, will there be enough qualified nurses, psychologists, and social workers to work directly with the patients? Unfortunately, there is also a serious shortage of social workers in psychiatric programs throughout Canada. There is a dearth of data concerning staff shortages among the other members of the psychiatric team, but the problems are no less real or serious. In the U.S.A. during a 5-year period (1963-1967), hospital staffs increased by 36.6 percent, while the staff-resident ratio declined from 1:2-1/2 to 1:2-1/3. This decline is probably related to the increase, approximately 3 percent per annum, in the number of residents in public institutions for the retarded. In practical terms this means that the personnel situation has steadily worsened.

---

* The estimated cost of training a physician is $60,000.

** Titmuss (1967) says that "since 1949 the U.S. has absorbed 100,000 doctors, scientists and engineers from developed and developing countries. The U.S. will save $4,000 million over 18 years by not having to educate and train, or train fully this vast quantity of human capital."

*** This far-from-merry medical-go-round has recently been the subject of an editorial in the British Medical Journal (1969), where it was pointed out that 43 percent of the hospital junior posts in Britain were staffed by overseas graduates. Large numbers come from Egypt, Iran, and Pakistan, and for many it is difficult to find employment.

Statistical evidence (British Columbia, 1967; Ontario, 1966) indicates that at least as far as British Columbia and Ontario are concerned, mental retardation institutions in Canada labor under much the same difficulties as those in the U.S.A. In both countries the institutions are overcrowded and short of professional staff.

The Value of Institutions

Institutions for the mental retarded have a high rate of staff attrition, probably reflecting low employee morale. Assuming, as we must, that this is the rule rather than the exception, the value and purpose of such institutions must be questioned.

Klaber's (1969) conclusions are particularly relevant to this review of manpower problems. Here they are in summary:

> Unit size is more critical to institutional effectiveness than over-all staff ratios. One attendant with 10 children will be more involved with them than will 10 with 100 children. Creation of and attention to smaller units is therefore of vital concern.
>
> The contribution of nonattendant personnel is so great in relation to their relative number that the designation of better educated and better motivated people for special purposes is necessary. Ideally, such people would be trained occupational or recreational therapists in charge of nonprofessional personnel.
>
> Supervisory and promotional policies of institutions should be reevaluated. Promotion from the ranks is only minimally effective and perpetuates old and often undesirable policies.
>
> Institutions are reaching their limits in the use of untrained personnel. In-service training programs have shown to be ineffective in modifying existing behavior patterns.

Research data leaves no doubt that children placed in overcrowded, understaffed institutions do not progress we well as those who remain at home. Tizard and Grad (1961) and Susser (1968) have shown that this is true in England as well as in the U.S. But the demand for institutional care shows no sign of diminishing. In 1966 there were 31,000 people on the waiting list for U.S. institutions. The U.S.

Department of Health, Education, and Welfare (1968) reported "...for every person released or dying in an Institution, almost 2.5 persons are waiting for admission... ." In Ontario the situation is not much better. In 1964 hospital schools were overcrowded by 10 percent, with 1,200 on waiting lists.

Studies by Foulkes et al (1965) and Appel and Tisdall (1968), as well as those undertaken in England (Tizard, 1964; Susser, 1968) show that admission of retardates to hospitals is sought, and often secured, for social rather than clinical reasons. Instead of dealing with the social and economic problems, community agencies not infrequently pressure parents to have the retarded child committed.* Andrew (1965) and her colleagues at Michigan found that medical specialists advised commitment to a greater degree than nonmedical specialists, and that their advice was frequently unrelated to the degree of handicap. This misuse of scarce resources is harmful to society and the child and punitive for the parents. Tizard (1964) has also pointed out, "The greater the number of mentally handicapped children who are taken out of the community, the more unfavorable community attitudes become toward those who remain at home, and the harder it is for a family to keep such a child at home."

MR Clinics

Such findings raise doubts about the effectiveness of mental retardation clinics and whether they serve only a select group of families. This was suggested by Wortis and Wortis (1968) after a 10-year study undertaken in Brooklyn, New York. They state that:

> The specialized retardation clinic can only find its most appropriate and useful role when it is an integral part of an organized program of community services. To be really effective, a program of this kind cannot rely on the voluntary search for clinic services by parents. The schools will have to take the initiative in providing complex diagnostic evaluations for all children suspected to be retarded. When such community programs are elaborated, the clinic will find its rightful place as a resource for the more complicated and severe problems, and this will serve useful functions in training and research. The specialized retardation clinics can no longer be regarded as substitutes for such comprehensive community programs.

---

* Beddie and Osmond (1962), in Mothers, Mongols and Mores, poignantly illustrate the medical pressures on mothers to give up defective babies.

2

Poverty

The close relationship between poverty and mental retardation, well-known at the turn of the century, has now been rediscovered by the U.S. President's Committee on Mental Retardation (1968). They cite these striking facts as evidence:

> Three-fourths of the nation's mentally retarded are to found in the isolated and impoverished urban and rural slums.
>
> Conservative estimates of the incidence of mental retardation in inner city neighborhoods begin at 7 percent.
>
> A child in a low income rural or urban family is 15 times more likely to be diagnosed as retarded than is a child from a higher income family.
>
> ...the conditions of life in poverty--whether in an urban ghetto, the hollows of Appalachia, a prairie shacktown or on an Indian reservation--cause and nurture mental retardation. We believe that attack on the fester points of poverty will also hit the causes of retardation in the nation's rural and urban slums.

Interim Conclusions

The data presented so far lead to the following conclusions:

(1) There is a grievous shortage of professional workers for mental retardation services, as well as for other areas of chronic disability. This much has been substantially confirmed by reports from the U.S. and Canadian sources already cited.

(2) The present demand for doctors and other health care professionals greatly exceeds the supply. This situation is likely to worsen in the next decade.

(3) Most institutions for the retarded are overcrowded, understaffed, and in buildings that are in poor shape. These realities adversely affect the morale of the staff and the well-being of the residents.

(4) Catastrophic deterioration of services will follow the continuation of present policies of luring scarce professionals from one country to another. The need for these staff members is as great in Asia, Europe and South America as it is in Canada, the United States and the United Kingdom.

(5) Research has shown that retarded children are much more likely to improve in their own environment than in large residential institutions. Despite this, parents are still being pressured by community agencies and family doctors into demanding admission to these institutions for their children.

(6) Most likely to be accepted for admission to institutions are patients from very poor or broken homes. They are admitted, regardless of their degree of disability or special needs, only they have been identified as "community problems." In many such instances, the primary reason for admission is the absence of appropriate services within the community.

(7) Middle class and educated parents of severely handicapped children make more frequent use of the special mental retardation clinics than do the financially poorer parents of moderately or mildly retarded children. Similarly, there is some evidence to suggest that the less well educated parents are underrepresented in the activities of the parents' associations. This point has been made recently (1969) by Dr. D.E. Zarfas, director of the Ontario department's mental retardation services.

Using Scarce Resources

Since there seem to be no immediate solutions to the manpower crisis, attention must be paid to making the most effective use of available professional resources. This means that the role and use of professionals in mental retardation must change rapidly.

Children's Psychiatric Research Institute

Both the University of Western Ontario and the Children's Psychiatric Research Institute in London, Ontario, have accepted the challenge of educating medical students and physicians in mental retardation. Lectures on the history, incidence, classification and diagnosis of mental retardation are given to second-year students. Third- and fourth-year students attend clinics as C.P.R.I. on the mental and physical examination of retarded patients.. A 12-month residency in mental retardation for physicians is also provided at C.P.R.I. in association with the University of Western Ontario. Thirteen residents have already completed this program, which started in 1961. Even more successful and popular are the annual symposia for general practitioners arranged in association with the College of General Practice. These programs, pioneered in Ontario by Professor Murray L. Barr and Drs. Zarfas, Keogler and Goldberg, should serve as a model for the rest of Canada.

Nursing

Wastage among nurses in subnormality institutions has been studied by O'Hara (1968) of the Monyhull Hospital, Birmingham, England. In 1958-59, while the national average in general hospitals was 27 percent, in mental subnormality hospitals the loss rate was 48 percent. In 1964-65 the wastage figure rose to the alarming figure of 70 percent. The Royal College of Nursing tried to explain why nurses leave: "It is possible that the poor recruitment and high wastage are due in part to lack of job satisfaction and low regard in the community and in the eyes of their peers."

O'Hara found that because nurses play so insignificant a role in subnormality hospitals, it is inevitable that they are regarded as inferiors in the larger family of nursing. What, then, are the medical, nursing and social needs of the mentally subnormal? Quoting the study of Leck et al (1967), O'Hara reports that only 0.3 percent of the patients in a subnormality hospital required skilled nursing. Thirty-five percent required basic nursing--bowel and bladder care, washing and dressing, etc. This requires no more skill than a housewife uses in caring for her family.

Occupational Therapy

Registered occupational therapists are infrequently employed in mental retardation institutions, even though it is not difficult to see that O.T. skills could be of immense value in a comprehensive training program for the retarded.

Burke and McGrath (1967) delineate some of the specific tasks that could be undertaken by O.T.'s and by semi-professionals working under them. These include muscle education and strengthening, prevention and correction of contractures, stimulation of movement and perception training for non- and semi-ambulant patients, vocational assessment and pre-industrial programs for ambulant patients over 21 years of age.

In defining the particular contribution of O.T.'s in hospital schools, Burke and McGrath (1967) recognize that occupational therapists, like other professionals, must get personal satisfaction from practicing their arts. The lack of specialized equipment and the undefined nature of their assignment to mental retardation cases often make it difficult or impossible for occupational therapists to identify with their chosen profession. These problems become more acute when O.T.'s are isolated from professional colleagues and overwhelmed with such administrative chores as the supervision of numerous aides and the control of materials and supplies. Job satisfaction is closely related to the opportunity to apply principles of occupational therapy and methods of treatment to patients. This is a vitally important element in the recruitment and retention of staff.

Another difficulty faced by the occupational therapist in mental retardation is the lack of literature of specific problems relating to the treatment of children whose physical and perceptual handicaps are complicated by severe language defects. Research and leadership is needed, and university physical and occupational therapy departments should be encouraged to explore this area.

Psychology

Baumeister's (1967) study showed that most departments of psychology in U.S. mental retardation institutions were staffed by subdoctoral personnel. He thought it unlikely that this would change because there are not enough doctoral level psychologists to fill service roles, particularly in an area traditionally held to be without hope or challenge. Furthermore, many superintendents stated that their needs were adequately met at the level of preparation provided by the master's degree.

Except for the important medical work on genetic defects and inborn errors of metabolism, the modern revolution in mental retardation has been dependent largely on the work of clinical psychologists. Now that mental retardation is being accepted as more an educational than a medical problem, the contribution of psychologists will be of even greater importance. Now that they will be free to function as equals among behavioral scientists and educators, senior psychologists will hopefully find their place in mental retardation more rewarding than they previously did.

Social Work

Like the psychologist, the social worker does not usually find work in mental retardation particularly challenging. Although the prospect of working as a member of a team seems inviting, in reality there is little mutual consultation. Primary agencies, where social workers set goals and standards for their professional contributions, are preferred as places of employment. The fact that institutions are isolated from the community is another reason social workers are reluctant to work in this field.

Those outstanding social workers who are making important contributions in the field of mental retardation spend a great deal of their time and energy overcoming the social handicaps of their patients resulting from prolonged institutionalization rather than from any primary disability. In this respect social workers would be profitably employed if they encouraged parents to keep their children out of institutions; where this is not feasible, they should see to it that the retardate's stay away from home is reduced to a minimum. In either instance, the social worker should be based in the community rather than in the institutions.

A community-based operation, as an integral part of the local family welfare services, would have many advantages. One would be the focusing of the community's total resources on meeting the needs of the retarded. Another would be the opportunity for community action to deal with much wider issues such as anti-poverty programs, housing, and recreation. Social workers would then be in an excellent position to provide leadership to a substantial group of community welfare workers, student work groups, etc. These developments would go a long way toward meeting the real needs of the retarded victims of poverty.

Education

"Though we have long accepted that men are but children of a larger growth, we have only lately realized that it is equally true that many defectives are but children of slower growth. Because the defective learns so slowly, people have been misled into thinking that he does not learn at all." (The Lancet, January 6, 1962).

It is generally accepted that every child has a right to an education according to his age, aptitude and ability. Despite this in many areas of Canada today, the main responsibility for educating severely subnormal children rests with the health department rather than with the department of education. Keeping the retarded outside the scope of education has taken its toll on these children and indeed on the teaching profession. The children suffer because, with rare exceptions, they are taught by unqualified personnel. Qualified teachers, who might otherwise be interested in careers in special education, are unlikely to accept employment in a facility outside the general educational services, where they would receive poorer remuneration, fringe benefits, etc.

In England and Wales, efforts are being made to transfer the responsibility for the retarded from health to education. When this happens, severely mentally handicapped children, now considered unsuitable for education at school, will become an educational concern. This shift from health to education has been recommended by Seebohm (1968). His committee report suggests that the junior training centers should be included in the educational services. The committee estimated that about 60 places per 100,000 total population* would be required.

---

* This estimate is based in Kushlick's survey for the Wessex Regional Hospital Board, 1967.

Ontario

Accepting the English estimate of 60 "special school" places per 100,000 population, it will be seen that a considerable increase in the number of teachers and assistant teachers will be required for Canada, if comparable services are to be provided. Following the publication of the Hall-Dennis report (1968), career prospects in special education seem to have been much improved and the outlook for handicapped children is much brighter.

The shift of responsibility for education of retarded children from health to education departments necessitates a considerable improvement in the quality and training of teachers for special education. Much more imagination and flexibility will also be needed for developing special programs to suit slow learners and others suffering from specific emotional or cognitive defects. School-work training programs, such as described by Jorgenson (1968) in London, Ontario, and Sigfusson (1968) in Saskatchewan may well provide the models for the future.

Teacher training programs from Oregon (Oregon University, 1967) and Saskatchewan (Saskatchewan University, 1969) also indicate that some university departments have accepted the challenge of preparing teachers to assume major responsibilities in the field of special education.

Nonprofessional Staff

Mental retardation literature, following the first report of the President's Panel on Mental Retardation (1962), is replete with articles on employing trained nonskilled personnel to assist professionals or to work directly with tht mentally retarded. In my view this will not solve the problem. It can only make a bad situation worse. At present, 90 percent of the staff working with the retarded in institutions have less than certified professional training. This does not necessarily reflect on their competence, but it does indicate an urgent need to raise standards by increasing the proportion of professionals, rather than diluting them further. Except for the school programs provided under educational auspices, the institutions themselves are much too custodial and inhibit learning and independence. This pattern can only be broken when sufficient numbers of professionally qualified staff are available to give direction to the new programs. It is difficult to say what the ideal balance between professional and nonprofessional should be, but there can be no doubt that the present ratio of one in ten is not it.

Given adequate supervision and operational objectives, graduates form community colleges and university arts courses could provide very useful services in community, as well as institutional programs.

Positions of this kind should be regarded as providing experience rather than permanent careers. Those graduates without training who show special aptitudes should be encouraged and assisted to complete professional programs.

The Future of the Institutions

From Texas to Toronto and indeed throughout the world, reports on mental retardation programs unanimously stress the need to develop community-based services to replace the old institutions. There is even virtual unanimity among the experts about what forms these should take. All these are important: regional planning, improved maternity care, prenatal health counseling, early detection and diagnosis of abnormalities, assessment clinics, family counseling for parents of retarded children, nursery schools, special classes, temporary residential care, guardianship, hostels, workshops, and recreational programs. These services must also be integrated and coordinated with the other health and welfare programs. Thus the needs of the retarded are seen as a part of, not apart from, the rest of the community.

Objectives

There are six basic objectives within this array of services: (1) primary prevention, (2) early case finding and diagnosis, (3) remedial treatment where possible, (4) maintenance of an environment which will aid adaptation and facilitate learning, (5) special education and training, (6) community acceptance to allow the handicapped person to remain and be absorbed into the social and economic system.

In case such objectives are thought to be idealistic it should be remembered that provided the child is not damaged by early separation from his parents and siblings, the prognosis for the mentally retarded is good. Two-thirds to three-quarters of all those identified as suffering from mild forms of subnormality make adequate social adjustments. They hold steady jobs, marry and rear families (Susser, 1968). If such a high proportion of the retarded were not additionally handicapped at an early age by the effects of poverty, the prognosis would most likely be even more favorable.

This wide range of community services--universally recognized as essential to prevent and ameliorate mental retardation--is held in check by the lack of money and human resources and by apathy, ignorance and resistance to change within the power structure. These restraints, which promote the alienation of the mentally retarded and mentally ill from our communities, are also responsible for the maintenance of the isolated custodial institutions euphemistically called hospital schools or mental hospitals. As long as such institutions exist, they will be used by harassed parents and by society as "warehouses" for human detritus. They will also be obstacles to the development of the new programs that are so desperately needed.

Out of compassion for all those segregated in the "warehouses" as staff members or patients, it is difficult to resist the temptation to patch and tinker with the institution in order to make it less noxious. Preoccupation with such work as recruiting subprofessionals and developing volunteer programs, valuable as it is, must be recognized as essentially a palliative measure. These institutions must be dismantled, not improved. They are harmful places, which have long ago outlived their usefulness.

The vast sums of money spent on maintaining these decaying structures should be invested in community programs. These programs should be for those residents who can now be better cared for in foster homes, hostels, nursing homes or chronic illness hospitals. Also, the qualified staff from these hospitals should be encouraged to transfer to community programs where their experience and skills will be challenged and put to good use.

Although these views may not have been articulated before in so blunt a fashion, it should not be assumed that such opinions about the future of the institutions lack professional support. They do not, as the important developments in England, Ontario, and Alberta have shown. The superintendent of the Idaho State Hospital and School, J.R. Marks, has also committed himself (1969) to the abolition of institutional programs and facilities:

> Get the professionals out where the people are, instead of bringing the hapless retarded to where the trained personnel feel more at home. The manpower shortage is far less than we would like to think; the problem here is poor distribution and utilization of our manpower resources. Why build artificial communities within institutional walls when there are better facilities with real parents all over the country?

BIBLIOGRAPHY

Albee, G.W. (1968). "Needed--a Revolution in Caring for the Retarded." Trans-action. Vol. 5. 3. 37-42, Jan.-Feb.

Andrew, G. et al (1965). "Parental Contacts along the Route to Institutional Commitment of Retarded Children." Amer. J. Ment. Def. Vol. 70. 3. 399-407. Nov.

Doll, E.E. (1967). "Trends and Problems in the Education of the Mentally Retarded: 1800-1940." Amer. J. Ment. Def. Vol. 72. 2-175-183. Sept.

Dunn, L.M. (1967). Special Classes for the Educable Mentally Retarded. C.A.R.C.

Foulkes, R.C., Hawley, C.M., et al. (1965). "Analysis of the 'Waiting List' in British Columbia." Amer J. Ment. Def. Vol. 70. 3. 413-422. Nov.

Gunzburg, H.C. (1968). "Postscript: re. The Role of Psychologists." J. Ment. Sub. Vol. XIV. Pt. 1. 26. 17-18-70. See also: (1956). "The Role of the Psychologist in the Mental Deficiency Hospital." Int. J. Soc. Psy. 1. 4. 31-36.

Hall, E.M. and Dennis, L.A. (1968). Living and Learning. Report of the Provincial Committee on Aims and Objectives of Education in the Schools of Ontario.

Jorgenson, G.E. (1968). Cooperative Work Training Programming and its Implications for the Trainable Retarded. C.A.R.C. National Conference on Mental Retardation. Oct.

Judek, S. (1964). Medical Manpower in Canada. Royal Commission on Health Services. Queen's Printer, Ottawa.

Kanner, L. (1967). "Medicine in the History of Mental Retardation: 1800-1965." Amer. J. Ment. Def. Vol. 72. 2. 165-169. Sept.

Klaber, M.M. (1969). "The retarded and institutions for the retarded--a preliminary research report." In: Sarason, S.B. and Doris J. Chap. 9. Psychological Problems in Mental Deficiency. 4th ed. Harper & Row 1969.

Last, J.M. (1969). "Community Demand for Doctors in the Next 10 Years." Brit. Med. J. Vol. 1.5646, 769-772. March 22nd.

Luckey, B.M. (1967). "The Contributions of Psychology to the Problems of Mental Retardation with Some Implications for the Future." Amer. J. Ment. Def. Vol. 72. 2. 170-175. Sept.

Marks, J.R. (1960). "The Future of the Institution." P.C.M.R. Message. 17. Feb. 1969.

McKerracher, D.G. (1964). Trends in Psychiatric Care. Royal Commission on Health Services. Queen's Printer, Ottawa.

National Advisory Commission on Health Manpower. (1967). Report: Vol. 1. U.S. Government Printing Office. Washington.

O'Hara, J. (1968). "The Role of the Nurse in Subnormality: A Re-Appraisal." J. Ment. Subnorm. Vol. XIV. Pt. 1. 26. 19-24. June.

Ontario Dept. of Health (1964). A Spectrum of Mental Retardation Services in Ontario: Report to the Federal Provincial Conference on Mental Retardation. Oct. 1964.

Ontario Dept. of Health. (1966). 100th Annual Report: Mental Health Div.

Ontario Dept. of Health. (1967). 43rd Annual Report for the year ending Dec. 31, 1967.

Oregon University. (1967). Selected Papers from: 1967 Special Study Institute for Personnel Engaged in Teacher Training in the Area of Mental Retardation. Sponsored by U.S. Office of Education.

Rea. N. (1966). "Training Teachers for Mentally Handicapped Adults." J. Mental Subnormality. Vol. XII, 23. Pt. 80-85. Dec.

Report of the Committee of Inquiry into Allegations of the Treatment of Patients and other irregularities at the Ely Hospital, Cardiff. (1969). Cmnd. 3975. H.M.S.O. London.

Retarded Infants Services, Inc. (1967). The Feasibility of Training Non-skilled Personnel to Assist Professional Staff in the Care and Treatment of Mentally Retarded Children. A Child Welfare Demonstration Project. New York.

Richman, A. (1964). Psychiatric Care in Canada: Extent and Results. Royal Commission on Health Services. Queen's Printer, Ottawa.

Rice, D.G. (1964). "Adult Workshops in Institutions." Mental Retardation. (C.A.R.C.) Vol. 14. 1. 24-25-27. April.

Royal Medico-Psychological Assn. (1967). "Report on the Training of Specialists in Mental Deficiency." Brit. J. Psychiat. 113, 495, 231-234. Feb.

Saskatchewan University. (1969). New Developments in Special Education. 1968-69. C.A.R.C.

Scott Report (1962). The Training of Staff of Training Centres for the Mentally Subnormal. H.M.S.O. London.

Seebohm, F. (1968). Report of the Committee on Local Authority and Allied Personal Social Services. Cmnd. 3703. H.M.S.O. London.

Sigfusson, E.A. (1968). Development of Saskatchewan's Cooperative School-Work Training Program. C.A.R.C. National Conference on Mental Retardation. Oct.

Susser, M. (1968). Community Psychiatry. Epidemiological and Social Themes. Random House. New York.

Tizard, J. and Grad, J.C. (1961). The Mentally Handicapped and Their Families; A Social Survey. Oxford University Press, London.

Tizard, J. (1964). Community Services for the Mentally Handicapped. Oxford University Press, London.

Titmuss, R.M. (1967). Welfare State and Welfare Society; 6th British National Conference on Social Welfare. Church House, Westminster, London S.W. 1. April 9th - 13th, 1967.

U.S.A. Dept. of Health, Education, and Welfare. (1968). Public Institutions for the Mentally Retarded; Trends in Caseload, Manpower, Expenditures. Div. of Mental Retardation. U.S. Govt. Printing Office.

U.S.A. President's Committee on M.R. (1968). The Edge of Change: A Report to the President on Mental Retardation Program Trends and Innovations, with Recommendations on Residential Care, Manpower, and Deprivation. U.S. Government Printing Office.

Vanier, J. (1969). Homes for Retarded Adults. Deficience Mentale/ Mental Retardation (CARC). Vol. 19. 2. 2-5. April.

Vowell, R.W., Sloan, W. et al (1962). "The Waiting List in Texas." Amer. J. Ment. Def. Vol. 67. 1. 21-28. July.

Wortis, J. and Wortis, H. (1968). "Who Comes to a Retardation Clinic? Implications for Social Planning." Amer. J. Pub. Health. Vol. 58. 9. 1746-1752. Sept.

World Health Organization. (1968). Organization of Services for the Mentally Retarded. 15th Rep. of the W.H.O. Expert Committee on Mental Health. Technical Report Series No. 392. Geneva.

Zarfas, D.E. (1969). Keynote address to O.A.M.R. Globe & Mail 25.4.69.

Discussion Highlights

Before specific educational and training programs are constructed, objectives must be set. This requires detailed job definitions and descriptions. Another prerequisite is to determine the role of supportive personnel in solving the problems of the intellectually retarded--whether they should be trained in regular ro special classes, and of the trainable retarded--whether these should be located in institutions, rural areas, or in cities.

Current attitudes toward supportive staff must change. Professionals must learn to accept the support that assistants and aides can offer. The role of supportive personnel has not been clearly evaluated and many barriers to its development exist. Universities require specific levels of competence and certain educational prerequisites before courses in mental retardation can be taken by students. In many areas, legislation prohibits supportive staff from taking on responsibilities for which they have been trained. Civil service regulations restrict the job responsibilities that may be undertaken and, in many instances prevent upward mobility on the career ladder. Before changes in the systems can be made, there has to be some assurance that the changes will improve the services to the consumer.

Suggested solutions to the problems include coordination of community college facilities, community services and professional interests. Community colleges have not been well used as resources for personnel. They have been mainly concerned with preparing the student for admittance to the university, and thus they have not offered well-planned courses suitable for students seeking careers in the various services to the retarded. Most applied courses are not acceptable to universities and as a result the students who take these courses are considered inferior. The universities should contribute to the planning for such courses and, in turn, the community colleges should work closely with community services to provide practicum areas. In so doing, faculty and students would provide services to the retarded during their education and training programs.

The development of "field professorships" could be one method for universities to work jointly with community services and community agencies. The "field professors" would be responsible for the supervision of students during their practicum experience in community areas and services. In turn, these professors work with the community colleges to develop and teach specific courses.

Some standardization of courses at community colleges and vocational institutes is needed. It was reemphasized that the need has to be determined. In addition to these needs, there should be (1) a well-coordinated approach to the "power structures" (e.g., government, voluntary agencies, professional organizations) by all the relevant professions, (2) provision for a career ladder for all levels of personnel, (3) modification of legislative and civil service regulations in areas where changes are needed, (4) acceptance by universities of credit for "practical" courses taken at community colleges.

There also needs to be a stepping up of in-service training programs in institutions, government agencies and community service programs. These should be geared for the untrained staff of attendants, orderlies, volunteers, and indigents currents requiring rehabilitation through job training. The courses should promote greater job satisfaction and provide greater stimulation for these service personnel. Grants should be made available for in-service training and staff development programs should be provided in the area of mental retardation.

On the professional level, all professions, e.g., physicians, teachers, public health nurses and other primary care specialists, should consider mental retardation within the mainstream of their work and not as a field apart; and students of the health sciences should have a greater understanding of special education. In certain disciplines, especially pediatrics, psychology and neurology, specific knowledge of special education should be imparted by specialists in that field.

Four techniques have been suggested to encourage interdisciplinary education and training:

(1) Facilities should be close together, and in some instances office space should be shared.

(2) Cross-appointments should be made within the teaching departments and on an extramural basis--that is within community services. Personnel from community agencies should also have university teaching appointments.

(3) Task-oriented committees should have representation from different disciplinary groups to add breadth and to ensure practical orientation to the problems at hand.

(4) The systems analyst and sociologist should be involved from the very start so that evaluation of the programs, the group processes, and the impact of supportive groups can be made.

The case worker or front line worker of the future is likely to be less well trained than has been the case. The reasons are that the indigenous worker has the necessary rapport with the local populations, and by serving as "screeners" and assistants they will enable an increase in the breadth of coverage available to the population. As they become more highly trained and experienced, they can serve as advisors to the front line workers.

Some in the discussion group felt that the public would object to this "watering down" of services caused by the use of relatively untrained personnel. There was also apprehension regarding the job satisfaction of the professionals under this scheme. It was pointed out that many professionals object to losing "patient" contact, as demonstrated by the trend back to bedside nursing by registered nurses. It was also indicated that if the role of the "professional" is to become more advisory, then this must be emphasized in the education process.

Objectives for the care of the retarded were outlined as follows:

(1) To assist the mentally retarded to function at their maximum capacity and usefulness. In many instances this will be achieved by assisting the retarded and their families to use all the available resources, enabling them to remain in the community. In other cases the objective may be better achieved by placement in another community or a special residential facility.

(2) The community or region should have a total spectrum of living, work and recreation programs available to the retarded in settings which minimize social and geographic distances and at the same time provide the impetus to involve those who cannot, on their own, take part in these varied programs.

It was emphasized that we should adopt standards of care that would support the eventual phasing out of large institutions. It was suggested that in the future institutions should not exceed a population of 500. The standards of the American Association of Mental Deficiency are reasonable for a start, and they should be expedited.

With greater emphasis on community care and services, there is a need for the development of two new categories of workers: one to provide personal, continuing day-to-day care in the community, e.g., foster parents and/or surrogate parents in group homes; and another of primary care workers in other community services including institutions, e.g., the counselor or staff specialist, the child care workers in day care centers, and the various categories of nurses, nurses' aides, etc. It was suggested that foster parents should receive in-service training to help them understand the needs and management of retarded children. The main educational emphasis of such a program should be in child development, but avoiding the development of professionalism and the possible loss of empathy and good parent-child relationship.

The training of surrogate parents in group homes should include material on leadership qualities, child development, and independent functioning. It was emphasized that these parents need a maximum of support, but standards must be maintained. There was considerable disagreement about both the recruitment and training of this type of personnel. Further study and experimentation are necessary. In the meantime, institutions and service agencies must provide the initiative from training this type of worker. Unfortunately, the conference did not deal in any depth with the problems of motivation of personnel working with the retarded. This omission occurred in spite of Dr. Mayo's giving this top priority in his keynote address when he asked, "What can be done to make the challenge more compelling?"

New career opportunities should be developed for child care workers, staff specialists, special nurses and nurses' aides. Opportunities for advancement and competitive pay scales should also be adopted. Training and motivational incentives should be provided to high school and college students. Educating and training in this should be the responsibility of the community colleges and vocational schools in cooperation with community service agencies.

Recommendations arising from the Theme II discussion were:

(1) Standards should be set for all levels of basic and supportive personnel and the maintenance of these standards should be the responsibility of professional organizations, agencies, or regional groups, depending on the circumstances.

(2) State, provincial and federal authorities, in collaboration with training centers, professional associations and voluntary agencies, should establish accreditation procedures for all facilities serving the needs of the mentally retarded, particularly the residential facilities.

(3) Among the requirements of such accreditation procedures should be the in-service training programs for all categories of staff as well as of volunteers.

(4) In order to receive government subsidies, facilities should be required to meet the minimum standards defined by the accreditation procedures, which would include periodic inspection of the facilities.

THEME III

INTERNATIONAL AND INTER-UNIVERSITY RELATIONSHIPS

International and Inter-University Relationships

Introductory Statement

Patrick J. Doyle
President's Committee on Mental Retardation

Introduction

President Kennedy's Panel on Mental Retardation in 1961 made nearly a hundred recommendations to combat many of the inadequacies in the field of mental retardation. Among them were those concerned with the need for expanding international activities, including research, training, and service. Based on these recommendations, the Special Assistant to the President for Mental Retardation in 1963 formed an international subcommittee to begin implementing some of the earlier recommendations. One result, before the year was out, was a White House Conference on Mental Retardation, which also addressed itself to international activities.

It was not until 1965, however, that the Inter-American Conference on Mental Retardation took place in Puerto Rico. That meeting brought together leading educators, physicians, administrators and rehabilitation workers from South and Central America, the United States, and Canada. A number of the recommendations proposed at the Puerto Rico meeting are directly related to this conference in Canada:

(1) It was suggested that efforts be directed toward establishing international and national associations to enhance professional and scientific work in mental retardation. The proposed membership of the association was a group of specialized professionals, such as psychologists, educators, and physicians.

(2) It was recommended that regional mental retardation training centers offering high quality training for students from all the Americas should be established.

(3) It was suggested that administrators from university-affiliated training facilities in the United States give special consideration in their programs to provide professional leadership training in mental retardation, especially to Latin American professional personnel.

(4) The Puerto Rico conference also emphasized the need for further meetings where problems could be aired.

Subsequent to the Puerto Rico meeting, there have been meetings in Montevideo, Bogota, and Mexico City. This Canadian meeting is also an outcome of the Puerto Rico meeting, specifically emphasizing international manpower and reciprocal training between countries. The purpose of this position paper is to review some of the historical perspectives, point out the ongoing and potential programs, and make recommendations concerning future actions in mental retardation between Canada and the United States.

Present Programs

A number of agencies within the Department of Health, Education, and Welfare have been operating overseas programs in the field of mental retardation. The Rehabilitation Services Administration has been especially active in this area, with a project in mental retardation in Israel. The Children's Bureau has an overseas fellowship program under PL 480 which has enabled students to gain experience in foreign countries. Other agencies also have research projects abroad, most of them under PL 480. However, there are very few programs within the National Institutes of Health that place much emphasis on training in an international environment. Some attempts have been made by the National Institute of Child Health and Human Development, National Institute of Neurological Diseases, and National Institute of Mental Health to relate training to biomedical aspects. On the other hand, the Office of Education has done almost nothing in this field, either in terms of sending people from this country overseas or bringing foreign nationals to this country for training.

From time to time, the Pan American Health Organization and AID have brought people to this country for short periods of time to visit mental retardation facilities in a rather unstructured and somewhat casual way. Legislative attempts continue: Senator Yarborough has introduced Senate Bill 764 to assist international health and education.

The American Association on Mental Deficiency, under the direction of Dr. Harvey Stevens of the Committee on International Activities within the AAMD, has long had an interest in international activities. The Joseph P. Kennedy, Jr., Foundation in Washington, D.C., has been fostering activities specifically related to international research. The National Association for Retarded Children also has an international relations committee.

Medical schools in the United States which have university-affiliated training centers in mental retardation also should be interested in training foreign nationals in the field of mental retardation. One can cite particularly the University of Colorado and the University of Miami, which have been concerned mainly with training Latin Americans. The Children's Hospital in Los Angeles, under Dr. Richard Koch, has been trying to obtain training funds for people from abroad.

Possible Models

University-Affiliated Training Centers*

The President's Committee on Mental Retardation hopes that a number of university affiliated training centers in this country will take an active interest in and responsibility for training programs for foreign nationals. Several centers have shown strong interest in this regard, especially the University of Colorado, the University of Miami, the University of Washington, and Johns Hopkins University. A number of other universities are interested in the training aspect. Among these are the Department of Education at Columbia University, Peabody Institute, the University of Michigan, and the University of Wisconsin. Interest has been fragmentary and usually on a personal, one-to-one basis. Much of the funding for international programs has been assumed by the universities or by the individuals themselves.

One viable model for funding would be through the university-affiliated training centers. Special supplementary appropriations must be

---

* Grants for the construction of mental retardation university-affiliated facilities were authorized in Public Law 88-164 in 1963. These centers were established with the prime aim of training professionals in the biomedical, behavioral, and special educational disciplines in the field of retardation. Centers have been established at the following universities:

Children's Rehabilitation Institute, Johns Hopkins University, Baltimore
University of Colorado, Denver
Walter E. Fernald State School, Waltham, Massachusetts
Children's Hospital Medical Center, Boston
Georgetown University, Washington, D.C.
UCLA Neropsychiatric Institute, Los Angeles
University of Alabama Medical Center, Birmingham
University of Indiana, Bloomington
University of North Carolina, Chapel Hill
Ohio State University, Columbus
University of Kansas, Lawrence, Kansas City, and Parsons
University of Tennessee, Memphis
New York Medical College, New York City
University of Oregon, Portland and Eugene
University of Miami, Miami, Florida
Utah State University, Logan and Cedar City
Georgia Department of Public Health, Athens and Atlanta
University of Wisconsin, Madison

given to the UAC's for this. Applications for such supplementary funds could be reviewed by the same mechanism used for the present review of university-affiliated centers, with added advisory consultation with the President's Committee on Mental Retardation. It will not be easy to initiate such a program, because funds for the centers are restricted at present, but with help from the President's Committee, it is not impossible.

Joint United States-Canadian Study Group Universities

We envision an exchange among the four universities represented at this meeting: The University of Toronto, The University of Calgary, The University of Nebraska, and The University of Michigan. (While it is true that the American universities do not at this time have university-affiliated centers, in effect they operate as training centers, though not officially designated as such.) These four universities are ideally suited for a four-way exchange arrangement. The funding mechanism could be arranged on a contractual basis or by project grants through the Department of Health, Education, and Welfare. The reciprocal training could include not only the biomedical but also the behavioral and educational fields.

Independent Arrangements

A third model for exchange is that of university-to-university. A number of schools are already doing this in the biomedical field. Under this arrangement, each assumes the expenses of its own faculty or students on an exchange basis. The individual schools are able to work out problems of credit, certification, etc. This should be encouraged, and perhaps an inventory could be compiled of all the universities in Canada and the United States doing this in areas related to health and education. Initiative shown by individual universities should be nurtured carefully, and perhaps special funds could be made available from HEW.

Whatever model is used, we hope that early evaluation techniques will be established so that a continuing analysis will be available.

In the preparation of this paper, inquiries were made to the United States Embassy in Canada and the Canadian Embassy in Washington. We were searching for ongoing reciprocal training programs in any field. Nothing could be found. Perhaps this joint United States-Canada meeting on mental retardation will become the opening wedge.

Problems of Funding

In addition to the sources of funds from the Department of Health, Education, and Welfare and other federal agencies, we hope that more involvement by private foundations will be forthcoming. So far, they have shown little interest. We also feel that private industry has not really been examined in this regard. Pharmaceutical industries might be a fruitful source of help for reciprocal training programs, especially in universities where an interest is shown by the separate departments in allocating more university funds to this type of training. There are no present possibilities of Fulbright exchanges between Canada and the United States, but this should be investigated.

It must be admitted, however, that prospects for funding are relatively bleak. In the United States, there seems to be a moratorium on international travel and reciprocal programs at the moment, partially because of the commitment to the Vietnam war. Nevertheless, there are some people who believe that as the war deescalates, there will be more opportunities for international reciprocal training, and therefore we should be ready with projects and programs when they occur.

The present administration wants industry and private enterprise to be involved in social programs as much as possible. One such source of help is the General Learning Corporation of New York, headed by the former Commissioner of Education, Francis Keppel. This group, and others concerned with hardware and delivery of educational services on a profit basis, should be encouraged to help in these programs.

Recommendations

(1) Since this is our first joint meeting, we recommend that this workshop study group of Canadian and American professionals continue as a permanent study group working closely with the President's Committee on Mental Retardation. Further, this group should set up a special subcommittee on manpower which will begin to look at models and mechanisms for establishing reciprocal training.

(2) We should collaborate with the international committee of the American Association on Mental Deficiency in working toward common goals. Another source for potential cooperation is the International Division of the Association of American Medical Colleges, which has branches in Canada, and a long history of medical exchange programs.

(3) The Canadian National Mental Health Ministry should establish an official ad hoc committee to explore reciprocal manpower training with the permanent study group.

Discussion Highlights

One of the first topics discussed was the need for an inventory and evaluation of existing job titles and descriptions. Such an audit is necessary for the definition of manpower needs and shortages and would save time and discussion in future conferences related to the topic. This discussion led to the first recommendation: that a joint committee and study group be named for the purpose of objectively defining and evaluating the various jobs in the field of mental retardation and then compiling a dictionary of job titles and descriptions.

A major discussion concerned exchanges on both national and international levels. It was felt that there was adequate opportunity for higher level professional staff, both at universities and institutions to travel for the purpose of studying new programs for possible incorporation into their own. However, such travel and exchange is still needed for nonprofessional supportive staff. In fact, exchanges at all levels of education and training should be encouraged so that everyone, from the student to the professional, both basic and supportive personnel, has the opportunity to enrich his views and approaches to various duties.

One result which could emerge from additional travel and exchange is an increase in the so-called "brain drain." Possible ways of alleviating this threat were discussed, including having the exchangee remain on the sending institution's payroll to ensure his return, yet giving him the benefit of training elsewhere. One-for-one exchanges and cross-appointments could be made, and a broad increase in them could improve services and training. Two specific recommendations emerged from this discussion.

(1) That for educational and training purposes, exchanges of staff and students--particularly at the level of supportive personnel--be encouraged between institutions and other service agencies for the mentally retarded of Canada and the United States.

(2) That personnel responsible for high-level decision making in our respective countries, e.g., board members, legislators and administrators, be encouraged to undertake field studies of programs within and outside their countries.

It was felt by some that many universities are more involved in national and international problems than in community life. Direct university involvement with community agencies and services is a goal to strive for, and in some areas it is being implemented through such features as accredited community services and programs, and accreditation of teacher education programs at the university by people outside the university in the field of mental retardation, i.e., the consumers and the teachers. A suggestion was presented to expand the university-affiliated mental retardation training centers to include Canadian and U.S. representation. Since this group represents major disciplines involved plus the various funding agencies, it could become a powerful voice in mental retardation.

Other proposals involving joint United States-Canadian cooperation included one to establish a joint committee on cooperative research in all areas of mental retardation; another to establish an international group for the advancement of mental retardation, to meet yearly to discuss specific issues or timely topics; a third to establish closer liaison between the Canadian Association for the Mentally Retarded and the President's Committee on Mental Retardation; and finally, a fourth to create joint national information centers. A specific recommendation outlining the last proposal was formulated: that in order to promote the collection and evaluation of data and the exchange of information on manpower, training, research and services, there be established joint Canadian and American national information centers.

Regarding the future of further symposia such as this one, it was the concensus that the planning committee should meet at a later date to assess this meeting and to determine the practicality of and the outline for a future symposium. A recommendation to this effect was devised: that subsequent meetings of this type be held regularly with wider representation, including official representatives of decision-making bodies and supportive personnel from participating countries.

It was agreed that meetings of this kind have great merit in stimulating and recommending positive action to those agencies that have the machinery necessary for implementing the recommendations. However, there was some debate as to just which agencies in Canada have the power to take such action. (In the United States, the recommendations made at this conference will be submitted to the President's Committee on Mental Retardation.) It was suggested that the National Institute for Mental Retardation would be an appropriate vehicle, pending its separation from the Canadian Association for the Mentally Retarded. It was also suggested that since Canada does not have a federal Office of Education, problems discussed throughout the conference regarding medicine and education should be set before the Committee of Ministers of Education for action in each of the provinces. It was felt that there must be cooperation on both levels of government in Canada--federal and provincial. Proposals should be made to the government to be implemented by the provincial governments, which play the major role in health, education and welfare.

Another benefit of this conference, perhaps the most important one, was the informal contact established with others of various disciplines. It was expressed by some that a desire to outline specific recommendations and their implementation could become a compulsion and that the real value of such a meeting lies in the contact and relations established, a natural outcome of which is an informal exchange of ideas in training and research--one of the objectives of this meeting at Banff.

SUMMARY SESSION

Discussion Highlights

The easing of pressure on professional training facilities to fill manpower requirements could be facilitated by a lowering of professional requirements in selected situations--for instance, reducing the requirements from a Ph.D. to a master's degree. Many persons possessing Ph.D. potential never go on to the advanced degree, and although some specific skills may be lacking initially, they can be acquired if necessary. The roles that professionals play are constantly changing, so less specialized persons may prove more adaptable and thus more useful in the long run. The correlation between job descriptions and actual job behavior is usually quite low, and when agencies begin anticipating future job roles and training their own staff to fit them, the non-Ph.D. person may prove to be the best investment.

A potential source of manpower for supportive staff positions is the high school graduate who now tends to seek employment in the business community. Such people do not lack energy and inventiveness, but present service facilities lack the rewards and provisions for exploiting these qualities. Relevant training based on community needs must be provided. New roles that allow vertical and horizontal expansion must be implemented. New value systems for rewarding vocational activities and training programs that allow regional mobility must be devised. In addition, the present staff must be provided with training facilities and incentives to help them do their job better. The implementation of more relevant training programs must use the resources of the consumer, the service groups, and the student and must evolve beyond the first stages of planning. Planners should attempt to avoid "academic trivia" (that is, "high standards" and "quality programs"), react more to available feedback, and become concerned with alleviating community and service needs. Feedback can result from conferences like this one, from meetings on the regional level, or from direct confrontations such as those on the university campuses today. It is also the responsibility of groups and organizations to communicate with the planners to ensure that their interests are being considered.

One of the problems of effecting change is that control of knowledge is in the hands of vested interest groups. They do not want their academic field to progress beyond their abilities. A solution that is successful in business is to establish in-service training programs built upon a general wide-based traditional degree. Such an approach implies a need for extensive interdisciplinary training at the undergraduate level, and to implement such training, funding must be directed at problem areas and not at the specific disciplines or vested interest areas of the universities. In addition, viable interdisciplinary work settings must be provided in fact and not just on paper. A possible model is the "shopping center" system, where all services are available, but only the services required to meet the individual's needs are used. Standards for training programs can be developed in cooperation with present accreditation procedures such as the AAMD system and through the instigation of bodies such as the National Institute on Mental Retardation in Canada and the President's Committee on Mental Retardation in the United States.

Implementation for change must take present facilities into account and might best be attained through a series of small changes, keeping long-term broadly-based objectives in mind. As President Kennedy said, "Trees take a long time to grow, so we should be out planting them as soon as possible." Emphasis on community programs for the mentally retarded can be used as a vehicle for supporting a series of small alterations while phasing out large isolated residential institutions and phasing in mainstream education whenever plausible. Although many problems have to be solved according to the situation, the delegates to this conference can return with ideas generated here and implement the strategies necessary to achieve the goals that they consider most important. To this end, approaches to governments and funding sources cannot be made on an individual basis, but ought to be presented on a broad basis, in a group, with integrated proposals being drawn up to meet long-term objectives.

To achieve integrated objectives, communication must be enhanced on both interregional and international planes, perhaps through established bodies such as the NIMR, the President's Committee and regional groups. Coordinated action would also promote personnel mobility, creative cross-fertilization, and eventually information centers that will record and coordinate ongoing projects. When all spheres of influence are united for common goals, a good proportion of the resistance to change can be more easily overcome. One delegate chose to sum up this resistance by quoting the cartoon character Pogo: "We have met the enemy and they are us."

In conclusion, there was consensus that conferences such as this are useful in terms of idea-generation. However, some recommendations for future conferences were made:

(1) More definite focus on such topics as

- --delivery systems
- --models for interdisciplinary training and cooperation
- --the utilization of supportive staff personnel (the training of and attitudes toward such staff).

(2) A conference structure which permits more efficient cross-pollination of ideas and/or proposals for models of treatment, training, or diagnosis.

(3) A confrontation with front-line personnel and consumers (regional services and the people they serve).

(4) An opportunity to exchange models with delegates from other problem areas such as penology.

Summary

L.W. Mayo

As we bring this meeting to a close, I would like to say just a few words about two of the basic issues that were raised, and something about the philosophies which I think all of us support.

Regarding content, I would agree with Dr. Cochrane's challenge to us: how do you propose to deal with the practical problems? To answer this, let us refer to some of the comments made here this morning, including the one made by the Canada manpower supervisor who stated that we face real problems in manpower development for which we must devise methods of recruiting and of in-service, pre-service, and in-house training. I suggest that we establish a group appointed by the committee that set up this meeting to make arrangements for carrying out a meaningful, practical dialogue on how to select and train new personnel.

Universities have had their "ivory tower" concepts challenged by the students in an effort to make the university more relevant to the community. I think the idea expressed here this morning is that we must heed the advice and suggestions of the people in the field about whose training we are talking, so that we may avoid open confrontation. We need to work directly with the consumer, the universities, and the agencies involved when setting up training courses.

A meaningful dialogue is difficult to achieve, and past failures in attempting to establish such a working dialogue should not deter our efforts to see if it can be done in the field of mental retardation. Let us not sell ourselves short--we have the potential for change and should make full use of it.

Now something on the philosophy which we have heard expressed. One of the fascinating things about the period in which we live is the rapidity of change which we are experiencing. It is difficult to live with, to interpret and to understand. Therefore each of us must determine whether or not we are resistant to change or agents of change. I have been acutely conscious of this distinction as the students press for an immediate change and faculty resist change. I am satisfied that none of us in the professional world can any longer find our security in what we are or what we know, but rather in what we can become and what we can learn.

If we believe nothing really changes except for the worse; if we are losing faith in the power of an idea whose time has arrived (and that is the fulfillment of the full concept of the possibilities of what can be done for the mentally retarded in our society); if we have forgotten the power of one person or of a group with vision, ability and conviction to move mountains; all we have to do is look at the Banff School of Fine Arts. I believe the group present here can become an increasingly dynamic and even a revolutionary force in the development and implementation of a whole new concept of manpower, readily conceived, specifically constructed, and carried out not only in mental retardation but in related fields. It is vital that we move now, are practical and down to earth and aware of the "nitty-gritty." Remember, however, that being down to earth does not mean that we are justified in sacrificing quality for expediency. Fifty years from now this group will be known and remembered for its dreams and aspirations, for the action they have had on the lives and the destiny of our retarded citizens. Really, it is a difficult, complex and sober task to which we have put our heads, but I think we have to have the joy in the tackling of it and of feeling the thrill and stimulation of the challenge of it. And I believe that this group which has joined hands across the border has the competence, the ability, and the determination to move the whole concept of manpower in this field a long sea mile forward.

PARTICIPANTS[#]

* ALDRICH, Dr. Robert A.
Professor and Head
Division of Human Ecology
Department of Pediatrics
University of Washington
Seattle, Washington 98105

BATES, Dr. Percy
Assistant Professor of Special Education
School of Education
University of Michigan
734 East University Avenue
Ann Arbor, Michigan 48104

BEDDIE, Dr. A.J.
Director of Mental Retardation
Saskatchewan Training School
Moose Jaw, Saskatchewan

BENSBERG, Dr. Gerard J.
Associate Director
Center for Developmental and Learning Disorders
University of Alabama Medical Center
Birmingham, Alabama 35223

BOYD, Mr. W.N.
Assistant Deputy Minister
Department of Health and Social Services
411 Norquay Bldg.
Winnipeg, Manitoba

CAIN, Dr. Leo F.
President
California State College
Dominguez Hills
809 East Victoria
Gardena, California 90247

CAMERON, Dr. D.R.
Chairman
Professor Advisory Council
Centre for the Study of Mental Retardation
The University of Alberta
751A Education Building
Edmonton, Alberta

COCHRANE, Dr. W.A.
Dean
Faculty of Medicine
The University of Calgary
Calgary 44, Alberta

COHEN, Dr. Julius S.
Associate Director
Institute for the Study of Mental Retardation
The University of Michigan
611 Church Street
Ann Arbor, Michigan 48104

CRUICKSHANK, Dr. Wm. M.
Director
Institute for the Study of Mental Retardation
The University of Michigan
611 Church Street
Ann Arbor, Michigan 48104

DAVID, Dr. Charlotte
Director
B.C. Mental Retardation Institute
University of British Columbia
Vancouver, British Columbia

DORGAN, Miss H. Jean
Consultant
Manpower Utilization Branch
Department of Manpower and Immigration
Ottawa 2, Ontario

DOYLE, Dr. Patrick J.
Professor and Chairman
Department of Community Medicine
and International Health
Georgetown University
3900 Reservoir Road, NW
Washington, D.C. 20007

ELKIN, Mrs. Eleanor
President
National Association for Retarded
Children
Meadow Wood Apartments G 194
Warminster, Pennsylvania 18974

* GALLAGHER, Dr. James J.
Associate Commissioner of
Education
Bureau of Education for the
Handicapped
Regional Office Building
7th and D Streets, SW
Washington, D.C. 20201

GARRETT, Dr. James
Assistant Administrator
Social and Rehabilitation Service
Department of Health, Education,
and Welfare
330 Independence Avenue, SW
Washington, D.C. 20201

GETTINGS, Robert M.
Management Officer
President's Committee on
Mental Retardation
Washington, D.C. 20201

GIBSON, Dr. David
Professor
Department of Psychology
Faculty of Arts and Science
The University of Calgary
Calgary 44, Alberta

GREENLAND, Cyril
Canadian Association for the
Mentally Retarded
149 Alcorn Avenue
Toronto 7, Ontario

GUINDON, Miss Jeannine
Director
Centre d'Orientation
39 West Gouin Boulevard
Montreal, P.Q.

HATCHER, Mr. Frank S.
Chief, Vocational Rehabilitation
Pacific Region - Manpower
Sixth Floor, 1155 West Pender Street
Vancouver 1, British Columbia

* IVERSON, B.J.
Director
Welfare Grants
Department of National Health
and Welfare
Ottawa 3, Ontario

JONES, Mr. R.
Coordinator of Academic
Programs
Metropolitan Toronto School
Board
155 College Street
Toronto 2B, Ontario

* KUGEL, Dr. Robert B.
Dean
College of Medicine
University of Nebraska
Omaha, Nebraska 68105

LAZURE, Dr. Denis
Director of Child Psychiatry
Ste-Justine Hospital
3175 Chemin Ste-Catherine
Montreal, P.Q.

LEHMANN, Dr. Charles
Associate Dean and Professor
School of Education
University of Michigan
Ann Arbor, Michigan 48104

MAGRAW, Dr. Richard
Deputy Assistant Secretary
for Health Manpower
Department of Health, Education,
and Welfare
Office of the Secretary
Washington, D.C.

MASE, Dr. Darrel J.
Dean
College of Health Related
Professions
The J. Hillis Miller Health
Center
University of Florida
Gainesville, Florida 32603

MAYO, Dr. Leonard
Professor of Human Development
Colby College
Waterville, Maine 04901

McCREARY, Dr. J.F.
Dean of Medicine
University of British Columbia
Vancouver, British Columbia

MOONEY, Dr. Craig M.
Consultant in Psychology
Mental Health Division
Department of National Health
and Welfare
Ottawa, Ontario

PAPOVE, Mr. N.N.
Principal Grants Officer
Social Welfare Manpower Utilization
and Development
Department of National Health and
Welfare
Ottawa 3, Ontario

PURSLEY, Dr. Norman B.
Superintendent
Gracewood State School and
Hospital
Gracewood, Georgia 30812

* RABINOVITCH, Dr. M.S.
Associate Professor
Department of Medicine
McGill University
Montreal, P.Q.

RAY, Mr. David B., Jr.
Executive Director
President's Committee on
Mental Retardation
Washington, D.C. 20201

RICHARDSON, Mr. Howard E.
Assistant Director
National Institute on Mental
Retardation
149 Alcorn Avenue
Toronto 7, Ontario

* ROCKEFELLER, Mrs. Jeannette
1800 Center
Little Rock, Arkansas 72201

ROEHER, Dr. G.A.
National Executive Director
Canadian Association for the
Mentally Retarded
149 Alcorn Avenue
Toronto 7, Ontario

SAFRAN, Dr. Carl
Superintendent
Division of Special
Educational Services
Calgary School Board
515 McLeod Trail, SE
Calgary 21, Alberta

SHAW, Mr. R.F.
Vice-Principal (Administration)
McGill University
Montreal, P.Q.

* STUART, Mrs. L.J.
President
Canadian Assoc. for the
Mentally Retarded
610 Kenaston Avenue
Town of Mount Royal
Montreal, P.Q.

TYLER, Dr. F.H.
Director
School of Social Welfare
The University of Calgary
Calgary 44, Alberta

* WITTSON, Dr. Cecil
President
Medical Center
University of Nebraska
Omaha, Nebraska 68105

ZARFAS, Dr. D.E.
Director
Mental Retardation Branch
Mental Health Division
Department of Health for Ontario
Parliament Buildings
Toronto 5, Ontario

* Unable to attend

# Titles are given as of the time of the conference

★ U. S. GOVERNMENT PRINTING OFFICE : 1970 O - 381-734